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Autogenic analysis: the tool Freud was looking for

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Abstract *As implied by the paper's title, I think that I have discovered a technical improvement that fits better into the roots of psychoanalysis than into any one of its many current branches. My first point is that the 'abreactive phase' of psychoanalysis was prematurely closed for lack of appropriate tools to investigate the stream of consciousness, or, we should rather say, the stream of unconsciousness. After abandoning hypnosis and experimenting with other suggestion techniques (such as the laying of hands), Freud finally settled for 'free associations' or the reporting of spontaneous mental contents during the waking state. My second point, based on both historical and personal data, is that free association is a rather clumsy technique, and that it could, and should, be greatly improved. Instructing the average patient, as Freud did, to 'say everything that comes to mind, as it comes', is something like asking an anxious person to keep calm. In both cases, the instructions are appropriate, but quite difficult to comply with. Stating the goal is not enough; we also need instrumental instructions, that is, we have to teach the patient how to achieve those goals. This leads us to my third point: we have to teach technical procedures for attention management that are adequate for analytic work, rather than relying on the analysand's intuition to stumble upon some way to free associate.*

The phases of psychoanalytic development

The notion of neuronal excitation in response to external and internal stimuli, and its subsequent need for discharge, is basic for the development of psychoanalysis. Breuer and Freud, in their '*Studien über Hysterie*' (1893–1895), discuss the pathological potential of undischarged neuronal excitation in the following way: traumatic events that arouse strong unpleasant emotions set the stage for psychopathology when the unbearable mental representations related to the event become repressed. Then, the traumatic events have to find their expression in a distorted way, through hysterical symptoms or psychophysiological disturbances. This formulation forms the theoretical ground of the cathartic method of therapy: if the repressed memories of the traumatic event could be brought back to consciousness, and the associated affect allowed to discharge, a therapeutic effect should ensue.

The first difficulty of this approach was, of course, the resistance of the patient to re-experience what he had already decided was better not to experience at all. To overcome this emotional resistance, Freud and Breuer made use of hypnosis, a popular medical tool of their time. When placed in a hypnotic state, and encouraged to remember, the patient would often comply by recalling traumatic events, releasing in the process the accompanying affect by emotional expression. Clinical improvement usually followed the procedure, but it was often short-lived. It is true that the emotional resistance to remember traumatic events can

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be temporarily overcome during the hypnotic state, but the patient would repress again the uncovered memories in his normal waking state, and the attached affect would recover its pathogenic potential. Besides, the hypnotic technique introduces problems of its own, such as promoting strong dependency on the therapist, often with erotic overtones. This situation greatly interfered with the abreactive process, as Freud found, because, rather than uncovering his unconscious memories, the patient would tell what he felt the doctor wanted to hear. Furthermore, superficial clinical change could appear out of a desire to please the therapist, rather than from the discharge of repressed affects. So, Freud did abandon in frustration the hypnotic technique, diverting his efforts to the newly discovered phenomenon of transference. His interest shifted from the uncovering of traumas to the study and dissolution of resistances and transference, in the assumption that the unconscious memories would in this way come better under conscious control. As resistance consists not only of the suppression of unacceptable mental contents, but also on distortion of what is expressed, when the repressed ideas finally reach consciousness they do so in a disguised manner, and the analyst has to interpret the real meaning of those elaborations (Freud, 1904). Many reports of traumatic events turned out to be such distortions, and new recognition was given to the pathogenic role of unacceptable impulses and wishes, in contrast to the previous view that real traumatic life events were the sole determinants of psychopathology. Thus did Freud elaborate the concept of psychic conflict, together with that of the structural organization of the psychic apparatus, moving from the topographic into the structural theory. The goals of psychoanalysis enlarged, the mere abreaction of traumatic events became outmoded, and we became more and more concerned with the resolution of intrapsychic conflicts and the modification of the defensive organization, resorting to interpretations and other ancillary interventions.

Recently (de Rivera, 1997), taking account of the technical shift just described, I proposed to call the initial phase of psychoanalytic treatment 'abreactive', and the second 'interpretative'. According to some authors (for instance, Chessick, 1998), we seem now to be moving into a third phase, which regards the treatment process itself, rather than catharsis or interpretation, as the central mechanism of therapeutic change. Perhaps my technical proposal, which I initially thought of as a return to the past, can also be seen as part of this latest view. The training of the patient by the analyst in a deliberate procedure to access and to report extraconscious mental processes does create a most cooperative situation, a fact that, in itself, may be of quite significant therapeutic value. Furthermore, this new tool notably increases the autonomy and self-esteem of the patient, who knows first-hand what is 'wrong' with his unconscious life experience. Even if he has to rely on the analyst for learning and supervision of the procedure, he feels soon quite able to understand his unconscious processes, and thus more independent and self-reliant. In a way, we are shifting the emphasis of analytic work, concentrating more on the form of associating and reporting unconscious processes, optimally shaped with the appropriate technical approach, and less on its contents, which are quite idiosyncratic and therefore should not be influenced or tampered with.

As is true with most discoveries, what I am reporting now has been discovered and reported many times before. However, this is the first time, as far as I know, that someone emphasizes that the real work of analysis is not so much interpreting the meaning of associations, but teaching and supervising a particular technique of associating and reporting that bypasses conscious censoring and renders the hermeneutic efforts almost unnecessary.

Improving free association's technique

Quite candidly, Freud describes the evolution of his method of 'the talking cure' from the remembering under hypnosis of the situation in which the symptoms had first occurred, to

the suggestion that 'the right memory would occur at the moment I laid my hand on their foreheads', to the simple advice to report 'whatever comes into his head, even if he considers it incorrect or irrelevant or nonsensical, and above all if he finds it disagreeable to let himself think about what has occurred to him' (Freud, 1910). From this evolution, it seems clear that Freud was looking for some tool to enhance or facilitate access to unconscious processes. Instead, what he discovered were the mechanisms which blocked such spontaneous access, and the ways by which the unconscious (repressed) processes were to bypass them and come to the analyst's inspection. From the search of an appropriate altered state which facilitated free and clear expression of unconscious processes, the emphasis shifted to the hermeneutic analysis of unclear and inevitably censored associations, that somehow would betray their unconscious determinants.

One of the voices that first objected to the abandonment of further search for a good technique to unconscious access was Sandor Ferenczi (1929), who laid claim for further technical attempts to enhance the truthfulness of associations, that is, their proximity to undisguised unconsciouss contents. Although he tried many technical tricks, ranging from his active technique to the use of relaxation and neocatharsis, no real impact was made on the psychoanalytic movement, and the study of the analysand's discourse continued as it was produced, that is, full of resistances, reluctances, interferences and attempts to attract, manipulate and coerce the analyst.

Even Kris (1983) complained about the premature closure of the first topic, which 'for the first time placed a substantial distance between the technique of free association and psychoanalytic formulations of the mind'. Recomending the closest attention to the sequence, patterns and determinants of association, that is, to their form or process aspects, and not only to the contents, this author concludes that: 'The basic aim of psychoanalytic treatment … is to enhance the patient's freedom of association … free only in the sense of the patient's conscious intention to say whatever comes to mind, without reservation: thoughts, feelings, wishes, sensations, images, and memories'. The last point is appropriate, as the 'free' associations are, in fact, forced by an unconscious logic, the same logic that would be easily available for analysis were it not for the unavoidable interference of conscious and unconscious resistances. Yet, although Kris gives some useful advice for the analyst, he does not mention how to help the patient to enhance his freedom of association. Furthermore, he still relies on the patient's conscious intentions, as if achieving that most difficult and sofisticated mental task of free associating were just a question of good will.

To my knowledge, Aaron Beck (1976) was the first analyst who clearly formulated a method to free associate, giving to the patient on-the-spot technical indications for accessing spontaneous unconscious manifestations, or, as he called them, 'automatic thoughts': 'The standard method of emphasizing free association, overcoming censoring and interpreting resistances had not yielded the automatic thoughts … which just happened as if by reflex …' So, Beck instructed the patient in the following way: 'Whenever you experience an unpleasant feeling or sensation, try to recall what thoughts you had been having prior to this feeling' (Beck, 1976, pp. 30–33). Yet, even if Beck realized that his average psychoanalytic patient was 'not focusing sharply on the stream of consciousness', the method he developed did not focus on that stream either. He was able to sort out the difference between 'automatic thoughts' and the usual purposeful thinking, but the method he developed, now called cognitive therapy, fails to facilitate the uncovering of a continuous unconscious stream. As I came to consider later, his emphasis on willful and intentional efforts to sort out cognitive distortions in the automatic thoughts interferes with the natural unfolding of the associative stream, and paralyzes the therapeutic potential of further associating (de Rivera & Rodriguez-Abuin, 1998).

I stumbled first-hand upon the discovery of a different-than-usual associative process,

during the course of my own personal analysis. In the middle of an average session, quite unconnected with the rest of my discourse, a sudden flow of vivid images, accompanied by strong emotion, forced spontaneously upon my awareness, as if they had a life of their own. This phenomenon had a quite different quality than the rest of associations, and I reported it in amazement. I must have slipped, without any clear warning or intention, into some kind of altered state of consciousness, even as I was fully aware of my surroundings and of the whole situation. Later on, outside the analytic hour, I discovered that I was able to recall the whole experience at will, or, rather, to reinduce the peculiar state in which the experience made itself manifest. It was the first time, as far as I can recall, that I was exposed to mental material that upsurged spontaneously, and I was impressed by its almost hallucinatory quality. The content was rather interesting, as it consisted of an image of myself walking with my father, hand in hand, through an animated park, full of playing children, alongside a lake where graceful swans were swimming. The accompanying emotion was one of mind-opening, wondering awe at the sight of this magnificent unknown world, together with deep gratitude for the man who was taking me safely through it. It did have the quality of an eidetic memory, as details such as my father's worried expression, his brown coat collar covering half his face, the soft pressure of his hand, even the surrounding noise and movement, were clearly available, as if I had been transported to that very same situation. On further inquiry to my surprised father, we came to the conclusion that the actual event had taken place when I was about 5-years old. My analyst did not seem to share my excitement; my associations soon returned to their usual dull, intellectual quality, and not much use was made of this 'hallucinatory' experience. However, I know it did have a deep impact on the reshaping of my inner world, and I have later seen how similar experiences do have a strong effect on my patients' evolution.

As I was trying to make sense of that experience, Luthe's (1970) concept of 'brain directed' versus 'trainee directed' mental phenomena helped me greatly. As an alternative to the differentiation between conscious and unconscious processes, or between primary and secondary process, this author offers a classification based on the degree of voluntary control of mental processes, differentiating between those that occur 'on their own', which he attributes to automatic brain activity, and those that are more or less purposefully produced by the subject, which are the expression of the use he makes of his brain, so to speak. Instead of relying on the haphazard presentation of the peculiar state of mind that facilitates the first kind of manifestation, Luthe described a discrete altered state of consciousness, which could be reliably and easily induced by an attention-management technique, and in which such vivid spontaneous manifestations of emotional discharge were easily obtained.

Coming back to the cathartic method, I came to realize not only the added value of Luthe's technique, but also the quite meaningful discovery that unbearable mental representations could become repressed not only because they may arouse an unpleasant emotion, but also because, as Freud said, they have the quality of being 'incompatible with the dominant mass of ideas constituting the ego'. Freud (1918), who had observed the phenomenon from a different stance, related it to 'psychical inertia', which he defined as the resistance of libidinal impulses to abandon their previous objects and modes of discharge. The incident from my own analysis I have just reported is a good example. The memory of my walk with my father, even if it aroused strong emotions, was not in itself traumatic. Quite the contrary, it represented an affectionate island among the dull memories of my childhood, and I did enjoy recalling it, on purpose, many times afterwards. If it was repressed, it must have been for some other mechanism than the one underlying emotional resistance. So, besides emotional resistance, that we can define as the unconscious refusal to experience the disphoric affect associated with the repressed idea, we have to consider a second type of resistance, of a plastic or structural nature, related to the resilience of psychic structure to reorganize itself in order

to include previously unavailable mental contents. Logical incongruity, rather than its unpleasant quality, would force part of life experience out of consciousness. That is why mere abreaction does not work, and a therapeutic relationship is needed to allow the therapeutic process to unfold. Hypnosis was useful to overcome the emotional resistance to relive (live again) traumatic experiences, but besides the major problems of inducing dependence and increasing suggestionability, it had other major drawback, namely, its poor effect on plastic resistance. The meditation technique I learned from Luthe in Canada had none of those drawbacks. Besides promoting independence and self-reliance, its systematic application subtly remodulated personality features, showing a strong inhibiting effect not only upon emotional, but also on plastic resistance. Because this meditation technique is known as 'autogenic training', I have choosen to refer to my own procedure as 'autogenic analysis'.

Insight is defined as the awareness of repressed ideas, and of their attached affect. Freud (1914) 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 strangulated by repression, similar to repetitive micro-abreactions. The view that intellectual insight does not, by itself, neutralize disturbing mental contents has been clearly stated by Alexander (1946), who introduced the concept of 'corrective emotional experience', probably following Ferenczi's lead on the need for empathy and tolerance with the patient's emotional experience. Rather than the isolated abreaction of a discrete traumatic event, it is the task of psychoanalysis to promote an ongoing unfolding of the associative stream of 'brain directed', i.e. automatic spontaneous, mental phenomena. The therapeutic effect is achieved by (1) the neutralization of traumatic emotional experiences; (2) the progressive reorganization of the psychic structures to include previously unacceptable mental contents; and (3) the progressive normalization of interpersonal processes.

Following upon the work of Luthe, I have been able to implement a method that both facilitates the access to unconscious material and the reorganization of psychic structure. Its inception is based in the understanding of two main modes of mental functioning: one which is active, constructive, goal-related and intends to produce an effect, and another which is passive, non-judgemental, discharge-driven, and exists on itself, without ulterior effects intended. I think that Freud's idea of free association comes very close to mode two, but without clear instructions, free association becomes a haphazard mixture of both modes, with a tendency to slip into mode one, and thus departing from the basic rule of psychoanalysis. My technique includes teaching the patient to distinguish between both modes of functioning, and purposefully allowing him/herself to function on 'mode two' during the session. The maintenance of mode two requires training on attention management, in order for the patient to technically induce in himself a particular 'state of regression in the service of the ego', characterized by psychophysiological relaxation, increased tolerance of dysphoric affects, and increased awareness of internal processes. While in this state, 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. As the traumatic events thus recovered tend to be distorted by the combined influence of contradictory information, repressed impulses and impossible wishes, the whole process requires a very careful, non-interfering, technical attitude by the therapist. In fact, the method of autogenic analysis requires a seemingly paradoxical stance by the analyst, who, on the one hand, is most demanding as to the details of the technical procedure of attention management, and, on the other, is most permissive and supportive as to the nature of the contents yielded. I think I am right in reinterpreting Freud's abstinence rule to what we call the 'non-interference' principle. It is not so much keeping the patient in a state of frustration that matters, but

teaching and helping him to function analytically, in such a way as to ensure that the free association stream does not get interrupted, diverted, tampered with and, in a general way, interfered with by other processes, either of a conscious or unconscious nature. In order to supervise the compliance with this principle, the analyst has to pay close attention to the shape formal processes through which the dynamics become manifest, and not only to the contents. Subtle formal changes (such as the loss of definition of a previous eidetic image), sudden thematic shifts, premature task disengagement with return to the usual state ('mode 1'), etc., may be indicative of interferences at work.

Attention management training

More than a specific mental faculty, attention is a global aspect of cognitive functioning, in charge of priming and modulating the performance of other psychic functions. As a central mechanism that guides and regulates conscious activity, the practical study of the workings of attention seems most relevant for psychoanalysis. Before I explain what I mean by 'attention management', let me introduce a few notions about attention itself. As we are concerned with subjective experience, the best initial approach to the study of attention is the self-observation of its many different ways in our own conscious life. William James (1890), in his well-known study on the 'stream of consciousness', gives a good example of this endeavor, which I will define as the objectivation of subjective experience. James consideres a first division of attention in external and internal, according to whether it applied itself to the surrounding world or to the contents of consciousness. As he noted, the amplitude of consciousness depends on a certain freedom of attention, with a progressive narrowing of the field of consciousness the more rigidly the attention is fixated into a given object, image or idea. A light but uncompromised concentration is the best state to enhance awareness, either of self (internal attention) or of the surroundings (external attention), a point with which Freud would agree. Hypnosis, the tool Freud first applied to his therapeutic technique, operates in the opposite way, by rigidly narrowing concentration of attention. So, according to the focus on which it is concentrated, we can divide attention into focal (fixated into a given object), global (which lacks any focus and is therefore equally distributed on all the field of consciousness), and diffuse (which drifts from one stimulus to the next without ever maintaining a clear focus on any of them).

If we consider the process of attention from the angle of its functional aspects, we can distinguish three basic modes on which it is exerted: *active*, with the attention voluntarily regulated by the consciouss desire to achieve a given objective, and *passive*, which does not pretend any concrete goal, and is indiscriminately open to all objects in the perceptual field. This last mode can be further subdivided, according to its strength or persistence, into receptive, which does not vary its quality regardless of its objects, and disperse, that lacks persistence and would be intermittently sucked into an active mode, depending on the attractiveness or intensity of the stimulus.

Mental states can be understood in the light of a combination of the different characteristics of attention, many of which belong quite naturally together. So, for instance, external–focalized–active attention is the ordinary executive way of going about our business in the average Western world; internal–diffuse–passive attention leads us to the daydreaming state that we were reprimanded for in school, and so on. An important aspect of attention, and one that confirms its status as a central mechanism, is that its different types are associated with characteristic emotional and psychophysiological patterns. Active concentration is regularly related to emotional activation, which may range all the way from light excitation to frenzied agitation, whereas passive concentration is usually related to emotional relaxation. Knowing from first-hand experience the different types and combinations of attention, it is possible to

learn how to purposefully self-induce different states of consciousness, rather than relying on its haphazard or casual occurrence. This is what I mean by 'training in attention management'.

In my practice I make use of autogenic training, a form of meditation which induces a slightly modified state of consciousness (termed 'autogenic state') by means of passive concentration on selected proprioceptive sensations. The method originated in Europe, and was perfected and further developed in Canada by Luthe, evolving into a complex and most effective form of psychotherapy. I have elaborated in a previous paper (de Rivera, 1997) on the usefulness of autogenic concepts for psychoanalysis.

As opposed to hypnosis, meditation states in general open or expand the field of consciousness. Those states can be reliably induced by the maintenance of a stable internal–global–passive–receptive type of attention. The objective physiological concomitants of the autogenic state have been reviewed in detail by Luthe, and are significantly similar to those described by Benson (1975) with other forms of meditation. Recording by questionnaire the subjective experience during the autogenic state of over 200 subjects, we were able to describe in detail the psychological characteristics of the state (de Rivera & Garcia-Trujillo, 1991), which can be grouped in three areas. In summary, we can define the autogenic state as a technically induced 'state of regression in the service of the ego', characterized by: (1) a reversal of the subjective experience of anxiety into a state of psychophysiological relaxation, (2) a marked increase in the awareness of internal processes, and (3) ocassional sudden 'discharges' or flashes of very relevant mental contents, usually of a disturbing nature.

The first manifestation is a most remarkable one, and its dramatic effects on anxiety are responsible for the misleading association of autogenic training with other relaxation techniques, such as Jacobson's method. If we define anxiety as a vague and diffuse feeling that something damaging is about to occur, we can define psychological relaxation as an equally vague and diffuse feeling that everything is in order and nothing bad could possibly happen. Albeit quite pleasant and useful in therapy, particularly in that of stress and anxiety disorders, this group of phenomena are not, to my understanding, the most meaningful for the therapeutic understanding of the action mechanisms of autogenic analysis.

More relevant for our purposes is the second manifestation, this one of a cognitive nature, consisting 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 course of the analytic session, to maintain the attitude of a descriptive observer of his internal processes. 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 (accidents, intoxications, etc.), spatial relationships, and mnemic material of nonverbal nature.

The third group of subjective phenomena during the autogenic state consists of sudden discharges or paroxystic phenomena of the most varied nature. While those discharges are rare, short-lived and rather simple during the basic training, they tend to develop into complex and vivid experiential sequences when the passive concentration on proprioceptive sensations is diverted and the attention is set free and open to all ongoing experience. In my view, this set of phenomena is just an enlarged version of the second manifestation of the autogenic state, the increased awareness of inner processes.

How the unfolding of a traumatic stream of consciousness does spontaneously launch itself is unclear, but it is obviously related to the whole therapeutic situation. Hence the outmost importance of establishing, developing and maintaining a therapeutic relationship that, besides its own beneficial effects, would enable the patient first to learn a quite new mental

ability, and, second, to face the most frightening inner experiences with a calm, detached, passive and accepting attitude. Continuous verbalization of all sensations, thoughts and feelings during autogenic analysis, a mandatory requirement in psychoanalysis, does play a part on the therapeutic process. The silent, purely internal experience is not enough and can dangerously worsen the psychopathology, a warning that should always be made to prevent attempts to self-analysis. Verbalization or description of inner experience has some effects on the mental working that go beyond its mere communication value. Freud (1915) considered that, to be conscious, an idea had to be connected with the linguistic system, or, as he says, 'the conscious presentation comprises the presentation of the thing plus the presentation of the word belonging to it' (p. 201). Of course, stating that a conscious idea consists of the idea plus its verbal representation does not mean that only verbalized ideas can be conscious, but only that the idea has to be verbalizable, that is, amenable to linguistic expression. This is exactly what happens during autogenic analysis, when visual images, sensory and motor phenomena and their accompanying affects become amenable to verbalization, and thus enter the field of consciousness.

Let me illustrate the peculiarities of my method with a few short clinical vignettes. An attractive professional woman in her early 40s was referred by the therapist of her severely disturbed teenage daughter. She was lively, successful, intelligent, but she could only talk, in a rather anxious and fidgety way, about her oldest daughter. It was clear to me from the beginning that they always had a most difficult ambivalent relationship, and that the girl had been unduly spoiled and pampered all her life, with the mother being unable to set any limits on her. To my amazement, she was simultaneously proud, anxious and guilt-ridden about the girl. Her second child, a boy, was quite normal and seemed to carry a life of his own, very much like the father. After some preparatory sessions, in which she learned quite easily the basic autogenic training, she felt relieved by the relaxation experience, and she was ready to take some distance from her daughter, and to concentrate more on her own feelings and motivations. Then, after technical preparation in advanced attention management, we started autogenic analysis proper. The first session was uneventful, as is often the case, and we were mostly concerned with the technical aspects of the procedure. On the second session, as soon as she started the verbalization of her inner experience, the relaxed state turned swiftly into one of disturbed agitation, soft sobbing became a frank crying spell, and she reported the view of a dying baby. She was brave and well-trained enough to keep the attitude of passive acceptance, quite complying with my technical instructions. She was able to return to 'mental mode two' (detached description of automatic events) every time that the dramatism of the images led her into 'mode one' (interfering with, discussing or commenting on the automatic events). As the emotional discharge abated, I carefully terminated the procedure in the technically appropriate manner. After she collected herself, back in the usual waking state, I asked her to explain what had just happened. Then I learned that her first child, a baby girl, died at the age of 2 months from acute viral meningitis. Nine months later, the now conflictive teenager was born. The whole episode was denied to such an extent that she never mentioned it to anyone, not even to me in my history-taking. She was surprised by the vivid recollections she just had, and insisted that she thought she had 'completely forgotten' the event. For the first time since I met her, she looked calm, collected and softly sad. In the course of therapy, other traumatic events and fantasies emerged, such as her living daughter being a reincarnation of the dead one who was back to punish her. Several sessions were needed for adequate neutralization of her delayed grief reaction. In the following months, there was a significant change in her jumpy defensive ways, with a progressive normalization of her family life.

Least I get caught in the false memory syndrome, let me anticipate that there is no way I can differentiate between the description of events that did happen and those that did not

happen. Neither can my patients, as nothing in the quality, richness, vividness or feeling of the experience gives any clue as to its real-life occurrence. Inner reality is not an isomorphic version of external reality. In other words, what happens to us is just one of the inputs we apply for the construction of our inner world, but there are many others. Some of my patients become so intrigued that they initiate careful historical investigations of their own past, in the attempt to get some external validation of their autogenic experiences. What is meaningful, though, is that, instead of the outrage and vindictiveness that the current literature reports in relation to the recovery of traumatic memories, in autogenic analysis the rule is a progressive loss ('neutralization') of its disruptive quality, with concomitant psychological improvement of the patient, and, most significantly, of his interpersonal relationships with 'traumatogenic' people.

A young professional in his 30s, with severe obssesive–compulsive neurosis, experienced in autogenic analysis very violent images of his father beating and dismembering him, as well as of severe fighting during which he did at times kill his father or was killed by him. This theme was interwoven with others of sexual abuse and perversities, which included transsexual changes of his own body image. The neutralization of the linked themes lasted for several months, after which they finally abated and were replaced by other dynamics. In the meantime, his real-life relationship with his father, always cold and distant, improved markedly, to the point that he was able to pay him an extended visit and to enjoy his company, 'for the first time in my life, as far as I could remember'. In parallel with the changes taking place on his inner world, he was able to discover and express new feelings in relation to his father, such as affectionate tenderness at the subtle failings of his old age, which, before, made him only angry and scornful.

As final, closing remarks, let me finish with one word of caution. The method of autogenic analysis, of which this presentation is just a preliminary introduction, has been elaborated following Freud's steps but with a different vehicle. If in external world travel we do keep at pace with technical developments, even as we may like to visit the same places our ancestors did, there is much to be argued in favor of doing the same with our inner explorations. The unconscious is the same, our way of accessing different. If my proposed technical development is found of interest by any of those of you who are looking for new paradigms for our science, I shall be very glad.

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Résumé *Comme indiqué par le titre de cet article, je crois avoir découvert une meilleure technique qui plonge mieux davantage dans les racines de la psychanalyse que dans aucune autre de ses nombreuses ramifications actuelles.*

Mon premier point, c'est que 'phase ouvreactive' de la psychanalyse a été close prématurément, par manque d'outils appropriés pour rechercher le flux de la conscience, ou pour mieux dire le flux de l'inconscience. Après avoir abandoné l'hypnose et expérimenté avec d'autes techniques de suggestion (telles que 1'imposition des mains), Freud se fixa finelment sur 'l'assotiation libre', ou récit de tous les contenus mentaux spontanés pendant l'état veille.

Mon second point de vue, basé sur des données historiques et des données personnelles, c'est que lássociation libre est une technique un peu lourde, qui peut, et doit, être hautement améliorée. Demander à un patient, comme le faisait Freud, de dire 'tout ce qui lui passe par la tête, tel que cela arrive', c'est comme demander à une personne dans un état d'anxiété de rester calme. Dans les deux cas, les instructions sont appropriées, mais assez difficiles à accomplir. Formuler 1'objectif, ce n'est pas suffisant. Des instructios instrumentales sont aussi nécessaires, c'est-à-dire, nous devons montrer au patient la faÇon d'atteindre ces objectifs.

Cela nous mème à mon troisième point: nous devons enseigner des procédés de gestion de l'attention, qui soient les procédés propres au travail analytique, au lieu d'espérer que l'intuition de celui qui doit être analysé le mème de quelque manière que ce soit à associer librement.

Zusammenfassun *Autogene Analyse: Das Werkzeug, das Freud gesucht hat Wie schon der Titel meines Aufsatzes impliziert denke ich, eine technische Verbesserung gefunden zu haben, die viel besser zur urspruenglichen Psychoanalyse passt als zu den vielen anderen aktuellen Formen dieser. Erstens glaube ich, daß die 'abreactive phase' der Psychoanalyse zu früh abgeschlossen wurde, da es ihr an Instrumentarien zur Untersuchung des Bewußtseinsstromes, oder besser gesagt des Unterbewußtseinsstromes, mangelte.*

Nachdem die Hypnose aufgegeben wurde und man mit anderen 'suggestion' Techniken experimentierte (wie z.B. dem Handauflegen), gab Freud sich schließlich mit dem freien Assoziieren oder der spontanen Mitteilung von Gedanken während des Wachzustandes zufrieden. Mein zweiter Punkt, der sowohl auf historischen als auch auf persönlichen Daten basiert, geht davon aus, daß das freie Assoziieren eine sehr unbeholfene Technik ist, die noch sehr verbessert werden kann/ muß. Einem normalen Patienten die Anweisung zu geben 'alles so auszusprechen, wie es ihm in den Sinn kommt' ist genau so wie einer nervösen Person zu sagen, sie solle ruhig bleiben. In beiden Fällen sind die Anweisungen zwar angebracht, jedoch ist es schwer, sich auch danach zu richten. Nur das Ziel festzulegen ist nicht genug; wir müssen dem patienten auch Instrumentarien in die Hand geben, damit dieser die Ziele erreichen kann. Dies führt uns zu meinem dritten punkt: Wir müssen dem Patienten Techniken beibringen, mit denen er sein Problembewußtsein schult, anstatt uns nur auf die Intuition des Analysierten zu verlassen, und dann rein zufällig oder frei assoziierend auf den betreffenden Gedanken zu stoßen.