Reexamining Psychotherapeutic Action Through the Lens of Trauma

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Abstract: Work with survivors of childhood trauma sheds light on the enigmatic subject of just how psychotherapy produces change. The focus of this paper is the observation that there are two fundamental change mechanisms in psychotherapy, catharsis and internalization. Each one has a different time course and different clinical characteristics including the role played by the therapeutic relationship. Catharsis is triggered by the presence of the empathically attuned therapist, while internalization is driven by the therapist’s slightly aloof stance of expectancy and the patient’s need for connection. Each mechanism has a different childhood origin. Taken together, these two mechanisms are sufficient to explain therapeutic gains in other forms of psychotherapy and with other pathologies.

After 120 years of practicing the “talking cure,” we still know relatively little about how it works. In what Jeremy Naham (1997 personal communication) has called, “moments of meeting,” we sense that something important is happening, but even with close observation it is difficult to discern just how and when lasting change takes place. Loewald (1960) has pointed out that, with relatively intact patients, change processes are subtle and hard to observe. Even when ego damage is more serious, making process more obvious, the action remains largely nonverbal and slightly outside of consciousness. Until recently, debate has tended to focus on positions clustered around the ideologically-based poles of interpretation and the therapeutic relationship.

Neither of these elements represents a basic mechanism of change, rather, they are agents of change. Both interpretation and the therapeutic relationship are complex, multifaceted phenomena that lead to therapeutic action but do not explain it. Going one level deeper, insight could be identified as the key component of interpretation and empathy the key element of the therapeutic relationship. Even so, insight and empathy still represent agents or facilitators of change, not mechanisms. In order to answer the more fundamental questions of just how change takes place, we must go yet another level deeper seeking basic, irreducible mechanisms of change.

Returning to the early roots of psychoanalysis in childhood trauma, in this

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paper I propose two fundamental, irreducible processes of therapeutic action found in the treatment of early life trauma, and I explore their relevance to treatment in general.

Major contributions to psychoanalytic theory have largely stopped short of exploring fundamental mechanisms. Descriptions of the action of treatment have been built on simple phrases and metaphors with little explanatory power. Freud initially satisfied himself with formula, “making the unconscious conscious.” Later, he stated in *The Ego and the Id* that the ego “becomes reconciled” to the threatening desires of the libido (1923/1955, p. 33). He did not further explore precisely what becoming “reconciled” might mean or how it happened. Strachey (1934) explored in detail the resolution of the *transference through “mutative interpretation.”* He described how the superego is softened by the “introjection” of the real external object, the analyst; but just how this “introjection” takes place is not further elaborated. Loewald (1960) established a foothold for the idea that the patient “integrates” a new, healthier object relationship derived from the therapeutic relationship itself; however, he is even more vague than Strachey about the precise nature of integration.

Subsequent to these classic contributions, the psychoanalytic literature has stayed largely at the level of agents of change rather than precise mechanisms. For example, Robert Emde (1990), a proponent of both the importance of empathy and the link between development and therapeutic action, offered the notion that the “special therapeutic atmosphere of shared meaning allows for a reexperiencing of the past such that it is not only less frightening, but becomes a potential source of affirmative continuity” (p. 906). How does this reexperiencing become structuralized as part of the self? Enrico Jones (1997) attempted to resolve the debate over interpretation versus relationship with an empirically-based integrative model of “repetitive interaction structures.” According to this view, “patient and therapist interact in repetitive ways over the course of therapy, and these ‘structures of interaction’ were related to patient change” (p. 1140). Once again, the *how* is not addressed. Currently, even with a widely held consensus that both insight and empathy are important, the psychodynamic literature has remained largely stalled at a level of abstraction that falls short of elucidating how treatment heals.

Another vital and still unresolved question addresses the relationship between psychotherapy and emotional development. If therapeutic action is based on the same mechanisms as child development, then the study of each can offer powerful insights into the other. This question, however, also, remains subject to debate. Only by having basic clarity about how treatment works can we begin to determine if therapeutic action is truly analogous to normal development.

Recent studies in neurobiology have awakened a new interest in funda-
mental mechanisms. Neurobiologists are moving rapidly toward characteriz-
ing pathways of therapeutic action, primarily in the establishment of new con-
nections between neural networks. Behavioral researchers have examined the
location and directions of changes in brain activity with both biological and
psychological treatments (Goldapple et al., 2004). Interpreting these results
will increasingly require more specificity about systems of affect regulation,
and behavioral control, including their location, functional interconnections,
and modification. While most of the work on integration of biological and
psychological data has been approached from the cognitive-behavioral tradi-
tion, the subject is well within the purview of the psychodynamic point of
view. Allan Schore (1994, 2003) has pioneered the integration of the psycho-
dynamic point of view with the new psychobiology. There remains a need to
focus specifically at the domain that lies between the psychodynamic under-
standing of therapeutic process and the dawning study of neural interconnec-
tions.

TWO ELEMENTAL HEALING MECHANISMS

The thesis of this paper is that clinical observation of trauma treatment
provides evidence for two, and probably only two, irreducible change mech-
anisms. Together, these two change mechanisms can be shown to be re-
 sponsible for the range of complex healing that takes place in treatment. I
refer to these two processes as catharsis and internalization. I go on to sug-
gest that each has a distinct time course, clinical characteristics, and child-
hood origin. Furthermore, I propose that the same two processes can explain
the range of therapeutic effects of other forms of psychotherapy and psy-
choanalysis. Finally, an understanding of these two processes will begin to
suggest answers to the unresolved questions about the roles of insight and
empathy and about the relationship between therapeutic action and child de-
velopment.

The first of these fundamental modes of healing was reported by Freud and
Breuer in 1893 in Preliminary Communication: “We found to our great sur-
prise at first, that each individual hysterical symptom immediately and per-
manently disappeared when we had succeeded in bringing clearly to light the
memory of the event by which it was provoked and in arousing its accompa-
nying affect” (p. 6). Avoiding new terminology when the old is satisfactory, I
refer to this remarkable healing process by Freud’s term, catharsis. While the
word catharsis has largely disappeared from our therapeutic vocabulary, the
process to which it refers lives on, much as originally observed in clinical
work with trauma patients. Even in modern cognitive-behavioral treatments
such as Exposure Therapy and Eye Movement Desensitization and Repro-
cessing (EMDR), detailed examination of the techniques suggests that the healing mechanisms differ little from Freud’s catharsis.

In addition to the early split between psychoanalysis and trauma treatment, perhaps another reason why catharsis has been seen as discredited is the fact that it heals only one part of the pathology of trauma. It is precisely this limitation that leads to the identification of a second change mechanism. Catharsis does produce healing of the recognized PTSD symptom clusters of intrusion, avoidance, and hypervigilence (APA, 2000). On the other hand, clinically important sequellae of early trauma include symptoms such as low self-esteem and inappropriate shame and guilt that do not respond to catharsis alone. The course and characteristics of the healing processes for this latter group of symptoms is so different as to suggest an entirely separate mechanism of therapeutic action.

Attitudinal symptoms such as inappropriate guilt and low self-esteem take much longer to heal. Even with persistent effort on the part of both patient and therapist, they do not resolve completely. These symptoms remain subject to reactivation by reminders of the trauma. Instead of cure, treatment seems to place a layer of new, positive values and attitudes on top of the traumatic negative ones.

This second healing process consists of taking in and somehow cementing new and lasting values and attitudes. Since we already have a common, generic term for such a process, internalization, I will make use of it in the belief that, in fact, it represents a single, and also irreducible, mechanism of psychic change.

In the course of this paper I will show that the two healing processes are distinct in many ways. In addition to having differing time courses and degrees of resolution, catharsis is particularly enhanced by warmth and empathy on the part of the therapist. On the other hand, recovery from low self-esteem and inappropriate guilt requires empathy plus confrontation, persistence, and an attitude of expectancy that change will happen. In reviewing possible childhood antecedents, I will again show divergence between the two processes. The next two sections examine the characteristics, first of catharsis, then of internalization in some detail.

**CATHARSIS**

This first known mechanism of psychotherapeutic healing has, unfortunately, been severely neglected in psychodynamic thinking. In the beginning of psychoanalysis, “making the unconscious conscious” referred to bringing traumatic memories to consciousness where they could be healed through catharsis. The main challenge in treatment was patients’ resistance to recall.
Dissatisfied with hypnosis and impressed that patients did not require it to re-
member, Freud gradually developed free association as the definitive method
for accessing repressed memories (Jones & Trilling, 1961).

Starting in 1897, when Freud publicly distanced himself from trauma, the
focus shifted to sexual fantasy and psychoanalysis began to extrude catharsis
from the mainstream. Strachey’s classic 1934 paper on therapeutic action
took the following position: While recognizing that catharsis could be perma-
nently curative in cases of “shell shock,” and recognizing that catharsis may
even be “an inevitable accompaniment of mutative interpretations,” catharsis
was not seen as structural in its effect. Strachey concluded that, “It does not
itself bring about any radical qualitative alteration in the patient’s mind.
Whatever part it may play in analysis is thus unlikely to be of anything more
than an ancillary nature” (p. 154). This assessment has gone largely unchal-
lenged. A recent search of the psychoanalytic literature shows not a single
title containing the word “catharsis” in the past 25 years.

In defining catharsis, it is important to distinguish between emotional heal-
ing and the dramatic recovery of repressed memories. Foa, Steketee, and
Rothbaum (1989) made the fundamental observation that emotional process-
ing is the same whether it happens after prolonged repression or immediately
following the trauma. If one thinks of catharsis as an emotional reactivation
of experience, during which healing takes place, then the process is identical
whether traumatic events have been repressed or have remained conscious.

Therefore, I will adopt a definition of catharsis, independent from remember-
ing, as the general process by which painful and frightening experiences lose
their power to evoke an intense emotional response.

A review of the clinical experience of cathartic healing of trauma suggests
that healing is rapid and largely nonverbal. Work with trauma patients, for ex-
ample, in the context of EMDR (Shapiro, 1995), confirms that increments of
healing transformation take place over a period of seconds. Not only is the
change rapid, but it can happen with minimal verbalization from the patient
and none from the therapist. Given these facts, one can conclude that cathar-
sis is an emotional process, not a cognitive one. Patient and therapist may
wish to construct a joint narrative of the events, but it is not the cognitive re-
framing that brings about catharsis.

The behavioral tradition provides an alternative view of the emotional
healing of trauma. While the actual conduct of behavioral treatments such as
Exposure Therapy have many of the same elements as psychodynamic treat-
ment, behaviorists explain it differently. Foa et al. (1989) saw the basis of
traumatic healing as a gradual “habituation” with repeated exposure to the
same material. In contrast, Freud (1893/1955) identified an all-or-nothing
process: “A recollection never returns a second time once it has been dealt
with.” But if it does return, it will be “accompanied by a new set of thoughts,
or the idea will have new implications” (p. 296). At a given time, a patient may only be able to access one aspect or one level of affective intensity, but for that portion of the experience, the healing is complete. The model of habituation by a repetitive wearing down fails to capture the clinical experience of a series of almost instantaneous, all-or-nothing shifts from a state of acute distress to one of relative serenity.

Not only is there a dramatic shift in reactivity, but there is an equally remarkable shift in the patient’s sense of perspective. In the midst of the emotional reaction to recall of a traumatic experience, patients tend to experience only immediate sensations, excluding any sense of a larger perspective. This loss of higher cognitive functioning has been correlated with decreased activity in the prefrontal cortex (Van Der Kolk, 2003). As healing takes place, patients regain a new sense of perspective over the trauma. Brain regions showing decreased activity come back to life (Levin, Lazrove, & Van Der Kolk, 1999). Let us examine this key phenomenon.

As patients begin to process traumatic experiences, they focus on specific sensory or affective aspects of the trauma. The parts are not yet knit into a whole story. They do not have perspective on the whole of the event. But the loss of perspective goes further. It extends to the dimensions of person as well as time and space. Traumatic events are experienced with a sense of immediacy. The focus is on the self, alone, without connection to a safe person. When healing occurs, it is predictably accompanied by an expansion of the sense of perspective. In a phenomenon sometimes referred to as “mindfulness,” the trauma begins to be seen as part of the flow of life.

Joseph Lichtenberg (2002), using terminology from Damasio (1999), described something similar: “Core consciousness,” which he associates with “trauma and affective intensity,” is characterized by “immediacy, perceptual veridicality, especially of body sensation, egocentricity of perspective, primitive causality, and relatively inflexible response patterns and inferences of archetypal identities.” He contrasts this to the state of “expanded consciousness” in which, “there is the sense of self and self with others existing on a time line of present, past and future” (p. 723).

The first state, which I would prefer to call “constricted consciousness” (Damasio’s “core conscious” may not be identical), describes precisely what is experienced by patients at the time of traumatization and later during recall. Lichtenberg’s description of the second state, “expanded consciousness” is equally evocative of the state of regained perspective that follows catharsis.

Assuming a cause and effect relationship between the under-activity of the prefrontal cortex and the state of constricted consciousness, what is it that awakens this brain region and triggers the dramatic transformation from constricted to expanded consciousness? Lichtenberg goes on to state that “safety and empathic resonance tilt toward expanded consciousness.”
It is the empathic resonance that holds the key to understanding catharsis. What differentiates therapy from the simple re-experiencing of trauma is the empathically attuned presence of the therapist. Based on human experience, both in childhood and adulthood, human contact is the ingredient that draws us out of the state of lost perspective. I would suggest that empathic connection is what awakens the prefrontal cortex, signaling that the emergency is over.

This statement may not seem very radical to working clinicians but, to a surprising degree, the importance of the empathic therapist has been under-emphasized or ignored and has not been adequately integrated into theory. Freud’s original description of catharsis failed to acknowledge the importance of the presence of the therapist. Likewise in the behavioral tradition, Foa et al.’s (1989) enumeration of the necessary ingredients in emotional healing again ignored the role of the empathic other.

In order to understand the importance of an empathic presence, I shall re-examine the role of aloneness in trauma. Not all painful or frightening experiences are traumatic. Accounts of prisoners of war and others strongly suggest that the availability of a sense of connectedness can prevent or reduce the degree of traumatization. Prisoners ascribe importance to such acts as writing on the wall in the hope that someone will eventually read their graffiti. Survivors see their relationship with God or loved ones as responsible for their survival. By contrast, those who are most traumatized are the ones whose pain and fear have been compounded by a subjective sense of isolation and aloneness.

Emotional aloneness makes pain more painful and fear more terrifying. This phenomenon is reflected in patients’ powerful resistance to revisiting traumatic material. The adult fear of remembering is the raw fear of a child who is untrusting, alone, and overwhelmed. By contrast, it is the reversal of this aloneness through empathic connection that modifies the terror and allows the patient to risk experiencing the painful affects in a new context of safety and connection. It is an interesting clinical paradox that in the midst of recall of trauma, the therapist can say, “you feel completely alone now,” and the patient will agree with the statement even though the patient’s ability to tolerate the experience depends on the opposite being true. During catharsis, the foreground experience is aloneness, while the background or contextual experience is one of empathic connection.

The idea that emotional relatedness modulates experience is part of everyday experience as well. When a friend receives a diagnosis of possible cancer, our presence does not change the odds of death, but our empathy can sharply reduce the grip of fear. While current theory emphasizes the impact of powerlessness associated with trauma, it is not the facts of the situation but our subjective experience of relatedness or lack of it, that determines whether we feel powerless.
In treatment, as the patient revisits feelings of aloneness and powerlessness, the therapist’s empathic presence allows a transformation of the experience. The aloneness and powerlessness are not removed, but re-contextualized, and thereby healed.

Study of the neurobiology of emotions has recently led to new interest in fundamental mechanisms, including the healing of trauma. Research by LeDoux (1996) indicates that, while traumatic memories are permanently laid down in the amygdala and probably cannot be erased, the emotional response to them can be modulated by signals from the nearby prefrontal cortex. The mechanism of this healing is thought to be that the activated traumatic memory becomes paired with the mental representation of a context of safety and comfort. As this happens, new neural associations form in the prefrontal cortex, which suppress further emotional arousal. In effect, the traumatic memory trace becomes re-contextualized with a new sense of safety. LeDoux put it thus: “Therapy is just another way of creating synaptic potentiation in brain pathways that control the amygdala” (p. 265).

Since Freud’s Preliminary Communication, one thing that both analytic thinkers and behaviorists agree upon is that for change to take place, emotions must be activated. Cozolino (2002, p. 315) suggested, that there may be a physiological explanation. The principle of Hebbian plasticity formulated by Donald Hebb in 1949 states that new functional connections between neurons are made only when pairs that are already synaptically joined happen to fire at the same time. “Neurons that fire together wire together.” It may be that the activation of emotion is the source of the simultaneous firing needed for new functional connections to form.

Below, when examining childhood antecedents, I will show how catharsis grows naturally out of the child’s use of the mother’s emotional attunement for affect regulation. So far, my emphasis has been on empathy as a healing force. In the next section, the emphasis is on “expectancy.” In fact, it is in the area of internalization that failures of empathic attunement can trigger clinical gains.

INTERNALIZATION

Successful cathartic healing still leaves behind what are perhaps the most damaging sequellae of trauma. These are internalized, negative values and attitudes. In addition to the low self-esteem and inappropriate guilt mentioned earlier, a broad range of negative attitudes and values can be internalized. Examples include self-denigration, believing oneself destined to fail, idealizing or excusing the abuser, and fear of telling. Once established, these mental contents are semi-permanent, meaning that they tend to remain unchanged
over time and require strenuous effort to alter. In fact, clinical experience shows that any challenge to these values and attitudes will meet active resistance.

Interestingly, the range and characteristics of traumatic internalizations exactly match the contents and characteristics of the superego. Conversely, the prohibitions, ideals, attitudes, values, and self-perception that make up the superego have the same qualities of durability and resistance to change associated with the negative attitudes resulting from trauma. It is a small step, then, to say that these negative values and attitudes are, in all likelihood, pathological superego contents. In other words, the superego is modified by the action of trauma. More specifically, the attitudes and values that are taken into the superego are derived directly from those of the abusers as perceived by the victim.

In seeking to understand the formation of these internalizations and their therapeutic modification, the parsimonious starting point is to assume that the internalization of all superego contents utilizes a single basic mechanism. Thus, the child’s internalization of the desire to be toilet trained, the victim’s internalization of self-devaluing attitudes, and the patient’s therapeutic internalization of positive self-regard, would all involve the same fundamental process.

Once again, in examining the process of internalization of superego contents, the extreme case of trauma gives us the most clear and accessible examples. Patients often recall the exact moment when “something shifted inside.” Consider the well-known example of the Patty Hearst story as described in the press. A young woman held captive in a closet internalizes the values and goals of her captors. Next, she is seen on video robbing a bank with her radical comrades. This story and other examples of trauma might lead one to conclude that the trigger for internalization is total powerlessness and loss of hope.

However, Conway and Siegelman (1995), writing on the phenomenon of cult indoctrination, described many cases where similar internalizations take place in a more positive atmosphere. The cult inductee actually desires to receive “enlightenment.” In a moment of heightened emotion and desire for belonging, inductees experience a sudden profound inner shift accompanied by physical sensations of lightness and energy. In all cases there is intense emotion but the trigger for internalization is something other than powerlessness or helplessness.

Freud addressed the issue of the origin of superego contents in *The Ego and the Id* (1923/1955). His account of the development of the superego outlined two routes. The first is object loss leading to internalization. For example, a girl who loses her father may take on more masculine traits. The other is the formation of internal prohibitions against the expression of the child’s...
own wishes. The classic example is the boy’s taboo against incest, in which he internalizes the father’s prohibition against sex with his mother. The two routes have a common denominator.

In both cases, internalization of aspects of the object helps to preserve a sense of connection. In the case of object loss, the connection is preserved by incorporating characteristics of the other into the self. In the case of incest, the boy’s connection with his father is preserved by internalizing the father’s prohibition. Not only is the goal the same, but so is the source of what is internalized. In both cases, mental contents originally identified with the other become a lasting part of the self. The internal monologue might be, “If I hold the same values and attitudes as you, then even if you are gone or if I have desires you wouldn’t like, we are still joined together.”

One can generalize that, in situations where there is fear of loss of connection, especially if we lack control over the other, internalization is a powerful and durable source of safety. Internalizing the other’s values, attitudes, or prohibitions creates an autonomous structure within the self that serves to channel behavior so as to avoid threatening vital social connections. These internal guiding structures therefore protect our emotional context so that the connections we depend on can survive special challenges such as death, separation, the other’s rage, and, in the case of toilet training, the parent’s desire that we behave in a quite unnatural way.

Thus it is my view that the common purpose of both normal and pathological internalization is the need to regulate behavior so as to protect a vulnerable sense of connection with the other. In traumatic cases, the role of deprivation, fear, and pain is to heighten the need for connection to the point where the individual is ready to abandon his or her own values and attitudes in favor of those of the perpetrator. In the case of the cult inductee, the individual starts the process in a state of intense need for identity and connection. For the child, ambivalence about “being good” implies a potential loss of approval, threatening the connection with the parent. In each instance, the trigger for internalization is not helplessness, *per se*, but the threat of loss of connection.

What about internalization in psychotherapy? As therapy progresses, positive values and attitudes begin to replace pathological, negative ones. The contents that are internalized represent the patient’s perception of the therapist and what he or she stands for. The motive force for this internalization is the patient’s desire for connection, heightened by an uncomfortable lack of control over the therapist. Threats to the patient’s tenuous connection, for example, the patient’s errant wishes or the therapist’s failures of attunement, are likely the triggers that induce each increment of therapeutic internalization. Sometimes positive values are simply reawakened, and sometimes they must be created. Often, positive attitudes toward the self have been acquired and
internalized early in life, but have been superseded by negative ones derived from trauma. In such cases, positive internalizations are simply reactivated. Otherwise, to a greater or lesser extent, they must be built de novo, a much longer and more difficult process for patient and therapist.

What about the neurophysiology of internalization? Schore (1994) provides an extensive review of the development, pathology, and modification of the ego ideal: “The internalization of selfobject regulatory functions takes the form of an orbitofrontal neuronal representation of the affective experiences with the externally regulating caregiver” (p. 368). “This frontolimbic structural system is identical to the ego ideal,” which he defines as “a comforting modality of the superego,” which can “access in evocative memory internal representations of the early nurturing, soothing, and shame regulating object” (p. 353–354). On the other hand, Schore does not localize the internalized attitudes, values, and prohibitions of the superego. The distinction is significant because these latter standards of behavior represent that part of the superego which is most resistant to change. In the section on childhood antecedents I will return to this differentiation between procedural memory and internalized standards.

The idea that the patient actively internalizes the therapist’s values is far indeed from the traditional therapeutic blank screen. However, we do universally embody a positive regard for our patients and, by oath, we stand for the value of health over sickness. In fact, it is a desirable outcome that these positive values should become internalized. Perhaps more radical is the notion that the motivation for internalization is the patient’s need for connection with the therapist. Ultimately, it is precisely this need for connection with us, along with our empathic attunement, that are the main sources of our power to heal.

Not all internalization takes place as rapidly as in violent trauma or cult indoctrination. All three kinds of internalization—normal, traumatic, and therapeutic—can, and often do, take place gradually over months or years. Slow internalization is, of course, harder to observe. The rule of parsimony again requires a single explanation. Until proven otherwise, slow internalization is assumed to follow the same mechanism as the rapid kind but in small increments. One clinical situation is at least suggestive of such an incremental model. Not infrequently, children who are mistreated are nonetheless defiant of their abusers. In spite of their defiance, these children still internalize negative attitudes. For these children, each act of defiance places a strain on the sense of connection with the adult and might be expected to trigger a small increment of compromise. The internal dialog here might be, “I defy you, but perhaps you are a little bit right that I am bad.”

As an aside, an interesting corollary to the idea of internalization being triggered by threatened loss of connection is the hypothesis that object con-
stancy might be acquired at moments of separation rather than periods of
closeness. The moment of “good bye” may be more crucial to its develop-
ment than hours spent together.

There are two other types of internalized mental contents that have
longevity and resistance to change, but are normally not associated with the
superego. First, pathological attachments or “trauma bonds” cannot be cate-
gorized as attitudes or values, but have characteristics similar to them. They
are certainly resistant to change and require persistence on the part of the
therapist. It is possible that these attachments may be neurophysiologically
indistinguishable from traditional superego contents. Second, oedipal age
children internalize quests or aims that they may pursue for a lifetime. These
are precisely the aims or wishes that, when conflicted, are the traditional
focus of psychoanalysis. These aims are not usually thought of as part of the
superego, but are as long lasting and exhibit similar resistance to change. For
example, the classic dynamics of the unresolved oedipal complex involve the
aim of someday winning the love of the parent of the opposite sex. Such aims
tend to remain unchanged over time, and to be as resistant to modification as
any superego value or attitude. These aims, too, may eventually be found to
exist in the same brain structures as elements of the superego.

CHILDHOOD ANTECEDENTS

Both catharsis and internalization, in forms essentially identical to those
observed in adulthood, play key roles in two basic regulatory systems that
appear in early life. Paralleling the divergence between the two kinds of
healing, the dual regulatory systems develop at different stages and fulfill
different functions. The first system becomes available at 9 months and reg-
ulates affects while the second develops at 18 months and guides behavior
according to the internalized templates or standards of the developing super-
egno.

The childhood equivalent of catharsis first becomes available during the
period of triumphant elation starting at about 9 months. The joy of this stage
arises not only from a growing capacity to engage the world, but an equally
important ability to cope with the inevitable painful affects that accompany
the child’s exploration. Almost wholly lacking the capacity to resist im-
pulses or control behavior, the child can only manage the end results, fear
and pain. At the same time, starting at about 9 months, “affect attunement”
(Stern, 1985) becomes available, allowing external regulation of affect. The
attuned mother’s ability to feel and reflect back the baby’s affective state is
not only immensely pleasurable for both, but it allows modulation of painful
affects.
When the toddler falls, she first makes eye contact with the mother. Her emotional response is a reflection of the mother’s reaction. Through a mechanism seemingly identical to catharsis, emotions are processed and detoxified in seconds, allowing the toddler to get up and go on playing. As with catharsis, there appears to be learning as well. With experience, the toddler develops expectations that moderate levels of pain and fear can be coped with. The experience of successful affect modulation becomes encoded in procedural memory.

On the other hand, when the empathic connection with mother is lost, the result is a shift in the child’s state of consciousness. The child appears to enter into the state of loss of perspective that I have referred to above as constricted consciousness. When this happens, the presence of an attuned mother can reestablish a state of connectedness and with it, expanded consciousness and its associated sense of perspective. Thus, affect regulation by an attuned mother and catharsis can be seen as two instances of the same basic emotion regulating mechanism in which empathic connection creates a new context for pain and fear.

The childhood antecedent of internalization, on the other hand, is the formation of the superego with its lasting values and attitudes. Schore (1994) suggests, that the capacity for superego internalization begins at about 18 months when the prefrontal cortex is first myelinated. This neurological event ushers in the ability to control behavior so as to prevent pain in the first place.

At 18 months, the child’s failures to manage behavior threaten the crucial empathic connection with the parent and trigger a new emotion, shame. This is the characteristic emotion of the rapprochement stage of separation-individuation. Shame becomes a powerful impetus for the control of behavior. Impulses must be resisted to prevent potential loss of the vital empathic connection. However, resisting powerful impulses requires something stronger than the anticipatory uneasiness of the previous developmental stage. A more powerful internal means of recognizing unacceptable behavior is required. For this new behavior regulator to function, the child must begin to internalize templates of acceptable and unacceptable behavior including prohibitions, ideals, and values. Stern’s (1985) description of the bedtime ritual of a girl of about 24 months gives direct evidence that fear of aloneness is indeed the trigger for internalization:

It was like watching “internalization” happen right before our eyes and ears. After father left, she appeared to be constantly under the threat of feeling alone and distressed. (A younger brother had been born about this time.) To keep herself controlled emotionally, she repeated in her soliloquy topics that had been part of the dialogue with father. Sometimes she seemed to intone in his voice or to recreate something like the previous dialogue with him, in order to reactivate his presence and carry it with her toward the abyss of sleep. (p. 173)
Compared to catharsis, internalization becomes available later, utilizes a different mechanism and fulfills a different purpose. Where catharsis functions to regulate the emotional impact of experience, internalization provides values and attitudes that help guide behavior and thereby maintain the security of the individual’s connectedness in the social milieu.

ARE THERE OTHER BASIC CHANGE MECHANISMS?

Cognitive Change

Catharsis and internalization are arguably basic, irreducible healing mechanisms, but are they the only ones? While proving a negative, in this case the absence of other change processes, is not possible, it is possible to approach the problem by looking at likely alternative candidates.

Since their origins in nineteenth century positivist science, both psychoanalysis and behaviorism have emphasized conscious cognition as the route to change. Despite many challenges, this emphasis has adherents today. Does cognitive change represent a basic healing mechanism? If not, what is the role of cognition?

Arlow and Brenner (1990), clear supporters of the supremacy of interpretation, summarize their view of the analytic process as follows:

What the analyst communicates to the analysand serves to destabilize the equilibrium of forces in conflict within the patient’s mind. This leads to growing awareness and understanding on the part of the analysands of the nature of their conflicts. . . . Thus in a series of related events, initiated and sustained by the analyst’s interventions, the range of the patient’s awareness is broadened, irrational anxieties are diminished, and the tendency toward resorting automatically to stereotyped responses in the face of perceived danger situations gradually diminishes. (p. 680)

Arlow and Brenner describe how interpretations “destabilize the equilibrium.” They further recognize that anxieties and stereotyped responses do diminish in analysis. But how exactly do we go from destabilization to change in responses? Is the process cognitive or emotional? Is it mediated by something other than catharsis and internalization? Let us take an example from the trauma field.

A female survivor of severe trauma had the following experience: Her father had abandoned her and her younger siblings when she was 8 years old, leaving her with a very psychotic and abusive mother. The patient had held the belief that she, herself, was to blame for her mother’s psychosis. While in treatment, now in her 40s, her father reappeared and, in the course of conver-
sation, revealed that the mother had been hospitalized before the patient was born. The patient suddenly flew into an uncontrollable rage.

Here is an example of cognitive change destabilizing a long-standing equilibrium. The patient’s rage at her mother had been held in check by her own self-blame. One small piece of new information removed the cognitive element that had bound her rage and the dam broke. This is a dramatic example of the same process of destabilization referred to by Arlow and Brenner. But does it reveal a fundamental healing mechanism beyond catharsis and internalization?

It is my contention that both cognition and the formation of defenses are basically fluid. Both ideas and defenses respond easily to outside reality. When we encounter resistance to new ideas in treatment, it is because there are underlying fears or conflicting values. Outside of therapy, ideas change instantly when contradicted by reality. Thus, cognition is not structural, but dynamic. In contrast, the action of psychotherapy and psychoanalysis is to bring about structural change, in Arlow and Brenner’s terms, the resolution of intrapsychic conflict. Resolution of conflict requires destabilization, but is actually achieved through the same two processes of healing as found in trauma. That is, activation of emotions, leading to cathartic healing and/or internalization of modified attitudes and values.

Cognitive change may be the goal of interpretation, but the therapeutic effect is indirect. New ideas destabilize defenses and set off emotional events which, in turn, result in structural change. For the patient in the example above, the release of rage led to cathartic healing such that her rage at her mother was never again as intense. It was only after the rage had subsided that she began to confront the disturbing possibility that she was not the bad person she had assumed herself to be.

In this example, the immediate healing mechanism was catharsis. Subsequently, she struggled much longer and harder with her internalized sense of being “bad.” Her awareness of the inappropriateness of self-destructive behaviors and attitudes led to behavior change. As she adopted more positive behavior patterns, she experienced renewed emotional destabilization. When she acted with self respect, she felt strange and guilty. These affects were processed in a cathartic mode till they no longer caused pain. With persistence, new positive values were internalized and became part of her identity and success in life. The process of internalization of positive values continued after therapy was ended. For example, cigarette smoking, identified during therapy as a negative behavior internalized directly from her mother, did not cease until several years after termination.

In summary, while cognitive interventions remain essential tools of psychotherapy and analysis, cognitive change is a relatively fluid phenomenon. New cognitions lead to destabilization of defenses and activation of emotions,
but they do not in themselves bring about structural change. Therefore, I do not feel that cognitive change is a basic, irreducible mechanism of therapeutic action.

**The Therapeutic Relationship**

Since Loewald (1960), the notion of the therapeutic relationship as an agent of change has become part of the mainstream of psychoanalytic thought. But does this make the experience of empathy or the relationship with a caring, reliable figure a fundamental change mechanism?

Like insight, the experience of a reliable relationship does not in itself produce structural change. In Strachey’s terms, it is not mutative. Structural change results when the paralyzing grip of painful emotions is released or when new contents are internalized. Empathy and relationship do facilitate the release of emotions and do provide the contents for positive internalizations, but they do not in themselves produce structural change. Conversely, even when therapy is stagnated or ineffective, it is not uncommon to find a positive relationship.

**GENERAL APPLICABILITY**

I now turn to the question of the applicability of catharsis and internalization to areas in psychotherapy other than trauma.

Catharsis is relevant to psychotherapy and psychoanalysis in general in that it represents the mechanism by which all kinds of painful emotions are resolved or healed. When we must let go of a cherished wish, we go through a grieving process. Talking about the loss in the presence of an empathic other leads to the same emotional activation and cathartic healing as in trauma. Other emotions such as anger, shame, and fear heal in the same way.

While the healing of emotions takes place through catharsis, this process occupies only a small fraction of the time spent with the patient. Much of the work of psychotherapy is aimed at destabilizing defenses to the point where emotion enters into the room and becomes subject to catharsis. Interpretation works largely to destabilize defenses so that catharsis can happen. Transference is an even more powerful destabilizer of defenses. As patients become caught up in transference feelings about the therapist, the barriers to emotion fail, and the immediate and powerful affects of childhood become manifest before our eyes and in our empathic presence. These are the conditions that bring about cathartic healing. As emotional healing takes place, patients gain perspective and begin to see more clearly how their emotions derived from early life rather than present reality.
On the other hand, as in trauma work, the healing of emotions is not the only fundamental operation of psychotherapy and psychoanalysis. Much of what needs to occur is the modification of pathological attitudes and values. For example, some patients insist on needing no one. Others demand absolute perfection of themselves. They may have prohibitions against legitimate joys and pleasures of life. These persistent, pathological attitudes and values are capable of generating anxiety, depression, and a wide range of psychological symptoms. As with the low self-esteem and the inappropriate guilt of trauma, the healing of painful emotions is not enough to alter these attitudes and values. As in trauma, there must be internalization of new attitudes and values to override the old, pathological ones. The two mechanisms of catharsis and internalization seem as relevant to other forms of therapy as they are to trauma treatment.

Let us briefly consider two characteristic examples of therapeutic work outside the field of trauma, first, the resolution of intrapsychic conflict, then the advancement of healthy ego development.

A hypothetical male patient suffers from sexual inhibition. He harbors a persistent unconscious sexual aim. As the transference develops, the patient’s sexual wishes become more intense and obvious. When it is pointed out by the therapist, shame and guilt are intense. As shame is activated, the empathic attunement of the therapist allows cathartic healing to take place. The acute shame subsides and leads to a sense of perspective. Now conscious of his unrealistic sexual wishes, the patient begins to relinquish them. A cathartic mechanism allows healing of the feelings of loss. The healing allows the therapy to move forward.

The patient feels less shame and begins to wish for a more appropriate sex life. His wishes bring him up against an internalized prohibition against all sexual pleasure. Interpretation of the conflict between superego and id brings his emotions into active turmoil. Simply by pointing out the conflict, a more permissive value system is implied. This initiates the slow process of internalizing a new attitude toward sex. Catharsis and internalization together are sufficient to explain the resolution of intrapsychic conflict. Note that in this case, as often happens, catharsis of painful affects and internalization of new attitudes may occur simultaneously, whereas in trauma, they are more likely to be separate.

Growth in therapy along developmental lines is another area where change involves the simultaneous action of catharsis and internalization. For example, a female patient with poorly developed impulse control begins to exert self-restraint. The act of waiting brings up feelings of strangeness, desperation, and anxiety. The therapist’s emotional attunement helps heal each new crisis of affect through catharsis. As the patient tolerates the affects, she finds it easier to resist impulsiveness. Her former identity as “party animal” begins
to be questioned. Self-mastery begins to be a source of pride and is gradually internalized as part of her value system. The internalization of new attitudes and values takes place in small increments with each crisis. At each point of emotional activation and change, both catharsis and internalization contribute jointly to the patient’s growth.

CONCLUSION

What are the clinical implications of this two-process view of psychotherapeutic action? There has been much debate over the balance between warm engagement with the patient and a more distant, impersonal stance. Catharsis is clearly fostered by warm, empathic engagement while internalization is triggered by a slightly aloof stance of expectancy on the part of the therapist. In the latter case, the therapist’s attitude of expectancy creates anxiety over potential loss of connection and, as I have suggested, this is what leads to internalization. Both empathy and expectancy are necessary for therapeutic action. More important, they are not in opposition to each other. Expectancy does not have to be at the expense of empathic attunement. The mother making eye contact with the toddler who has fallen, combines the two. She understands the pain while expecting the child to get up and go on. As therapists, we can be empathically attuned to our patients while being fully expectant that they will continue to take risks and grow. The art of being a therapist is to be both highly empathic and highly expectant at the same time.

References


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