UNCONSCIOUS DEATH ANXIETY AND THE TWO MODES OF PSYCHOTHERAPY

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> Nothing in biology makes sense except in the light of evolution.
> —T. Dobzhansky

> Go, go, go, said the bird: humankind
> Cannot bear very much reality.
> Time past and time future
> What might have been and what has been
> Point to one end, which is always present. —T. S. Eliot

> Gradually it has become clear to me what every great philosophy so far has been: namely, the personal confession of its author and a kind of involuntary and unconscious memoir. —F. Nietzsche

> There is properly no history, only biography. —R. W. Emerson

The four quotes given above sum up the history of psychoanalysis as seen through the lens of the adaptive approach to psychoanalysis and dynamic psychotherapy (terms I use interchangeably; Langs, 2004b, 2006). Their collective message suggests that we cannot properly understand the theories and techniques of psychoanalysis without a grasp of the forces that shaped their development, including the essential story of the lives of the individuals who gave them form and substance.

Evolution is cited first because it is the fundamental subscience of biology and, as such, is an embodiment of a set of archetypal principles like natural selection that are applicable to all manner of natural phenomena (Langs, 1996). Indeed, as Dobzhansky (1973) rightfully implies, we cannot deeply understand any aspect of psychoanalysis—which is after all a biological science, however little developed as such (Langs, Badalamenti, &

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Thomson, 1996)—unless we bring evolution into the picture. To do this, we must identify the entities that are most relevant to the present state of psychoanalysis and then forge a well-reasoned, scientifically sound *adaptationist program or evolutionary scenario*, however tentative, that identifies their most likely evolutionary trajectories and the crucial, passively acting selection factors that account for their past and present form and functions. In this connection, I shall propose two such evolutionary histories, both relevant to the present-day nature of psychoanalytic technique and the theories underlying them: first, the evolution of *the emotion-processing mind*, the mental module with which we adapt to emotionally charged impingements (Langs, 1995, 1996, 2004b, 2006), and second, the evolution of the discipline of psychoanalysis itself as carried forward by its founder, Sigmund Freud. These two stories are deeply intertwined and, taken together, shed considerable light on the ways in which dynamic psychotherapy is conducted today.

Evolution deals with survival under changing, life-threatening environmental conditions and thus with adapting to endangering physical and psychological realities. Humans have a unique conscious awareness of the existence of some aspects of this struggle because they alone have an explicit awareness of death. Even so, because the relevant issues are in many respects so overwhelming and anxiety-provoking, many death-related impingements are not experienced directly and are relegated to unconscious perception and registration. These inputs are then processed unconsciously, without the intercession of direct awareness; their presence and ramifications are conveyed solely through encoded narratives like dreams and stories. This aspect of emotional life is summed up in the quotation from T. S. Eliot, which recognizes that reality, rather than inner needs and wishes, is the basic emotionally driven problem in human life, largely because it unbearably points to but a single end.

Combining these first two quotations, it can be said that the explicit human awareness of death and the three forms of death anxiety it evokes—*predatory, predator, and existential* (Langs, 2004a, 2004b, 2006; see below)—which arose on the basis of language acquisition, are the fundamental issues in human life. They also indicate that these uniquely experienced, death-related

environmental challenges, broadly defined, also have served as the passively operating selection factors in the evolution of the emotion-processing mind. That is, humans with minds that coped well with these dangers tended to survive better and have progeny compared to those who coped poorly.

Adaptive studies of the evolution and design of the emotion-processing mind indicate that, in part because of the incredibly brief period of evolutionary time with which humans have had to adapt effectively to these threats, the adaptive operations of this mental module are badly compromised (Langs, 2004b, 2006). Much of this arises because the ultimate environmental threat for humans is unprecedented in the history of living beings—it is the explicit, articulated conscious awareness of the inevitability and finality of personal demise. As such, humans alone are faced with a basic environmental challenge that may be finessed over the short term but never in the long. This state of affairs and its effects on conscious thinking have had considerable unwitting influence on the theory and practice of psychoanalysis, which is a consciously wrought discipline that is based on conscious communications and their extractable implications.

The last two quotations given above, from Nietzsche and Emerson, move us from the evolution of the emotion-processing mind to that of psychoanalytic thinking and practice. They wisely suggest that we cannot fully fathom the state of psychoanalysis, past and present, without an incisive study of the biography of its creator, Sigmund Freud, in that his theory and the techniques derived from it are mirrors to the story of his life. Given the adaptive insight that death-related traumas are crucial to the path taken by a human life, the history of Freud's major traumas is likely to hold the key to the positive features and the grave flaws that have accrued to the psychoanalysis he crafted—and through inheritance, to its later-day derivatives.

There are at least four major reasons why standard biographers have not explored the links between Freud's early-life traumas and his psychoanalytic thinking (see, for example, Gay, 1988). First, they have not been able to discover a smoking gun, that is, a critical trauma or set of traumas that deeply influenced Freud's writings for better or worse. Second, they have carried out their investigations of Freud's life within the framework of

Freudian thinking, an approach that precludes the recognition of the errors he made and thus any need to account for them. Third, there is an overidealization of Freud that interferes with the search for factors that have given him feet of clay. And fourth, they have ignored or failed to comprehend the implications of biographical evidence that points to repressed early traumas that seem to have adversely affected Freud's theory and practice of psychoanalysis.

Detective work using the adaptive vantage point to investigate Freud's early life was instigated when it was realized that the approach's unique listening-formulating process, which was being used clinically to reveal patients' unconscious experiences and secrets, could be applied with considerable assurance to narrative writings such as those produced by Freud during his career as a psychoanalyst. The key tool for these efforts is a process called *trigger decoding*, which is a means of identifying patients' unconscious perceptions and adaptive processing efforts in response to significant, anxiety-provoking traumatic incidents. This decoding method was first used as a basis for refashioning features of present-day psychoanalytic techniques, and in time it was used to decode the narrative elements in Freud's major writings in the search for clues to his secreted early-life traumas. The motivation for this pursuit came from the clinical discovery of basic misconceptions in Freud's thinking, findings that prompted the search for biographical material pertaining to Freud's early life that provided clues to generally unrecognized traumas that could account for his missteps.

In 1912, Freud wrote that anatomy is destiny (p. 189). He also suggested (1917) that he had delivered the third great blow to human narcissism with his finding that the unconscious mind has far more power over our lives than the conscious mind—the discoveries that the earth is not the center of the universe (Copernicus) and that we have descended from the apes (Darwin) are the other two. However, the adaptive approach has identified a fourth blow to our hubris, namely, that among the countless realities that determine the pathways that our lives take, those that most affect us tend to involve incidents over which we have no say or control—for example, who our parents are, where we are born, our socioeconomic status, our level of native intelli-

gence, the experience of accidental natural disasters—and much, much more.

Because these explorations into Freud's life were stimulated by the recognition of flaws in Freudian thinking and clinical methodology, I shall first define the essential changes in both theory and technique forged by the adaptive approach. This effort will enable me to highlight the main problems in Freud's corpus and, thereby, in present-day analytic thinking and practice. I shall then turn briefly to Freud's early life and highlight the evidence for three largely unrecognized major early-life traumas that he seems to have endured and show how they adversely affected his psychoanalytic efforts. I will then comment on why, despite its evident flaws, Freud's position has been embraced in minimally modified form by those who have followed in his footsteps. A comparison of the classical mode of therapy and the adaptive mode, supplemented by a final discussion of unconscious death anxiety, will complete the article.

BASIC REVISIONS IN PSYCHOANALYTIC THEORY AND PRACTICE

As I begin my critique of Freud and present-day psychoanalytic technique, I wish to stress that my goal is to identify validated truths, always open to revision, that pertain to the field as it was forged in past years and exists today. This effort casts no aspersions on the sincerity and commitment of analysts and therapists to their theoretical beliefs and ways of practicing psychoanalysis or psychotherapy. Impressionistic sciences are notorious for their unnoticed errors and for their lacking the means of detecting their existence. It takes a breakthrough into a new system of observation and thought—a paradigm shift (Kuhn, 1962)—to detect these often critical flaws based on findings that negate existing ideas; in general, those who adhere to mainstream thinking are loathe to see and accept the revisions in theory and practice called for by the new findings. The adaptive approach lays claim to being such a paradigm shift and most certainly it has been met with stiff resistance from today's practitioners. My hope here is to make clearer than I have in the past the basis for the adaptive criticisms of psychoanalysis as it exists in principle

today, and to do so in a manner that recognizes the incompleteness of any theory and practice of psychoanalysis as it is currently fashioned. The next paradigm shift will, in its turn, find the inevitable flaws in adaptive thinking as presented here. Such are the ways of science to which psychoanalysis is no exception.

Adaptive revisions of psychoanalytic theory and technique began with a gradual shift in the basic orientation used by therapists to listen to and formulate the meanings of their patients' material and the implications of their own interventions. The essential change was from *inference-making* to *trigger decoding* as the basis for determining the *unconscious meanings* of patients' material. There was a downgrading of techniques like identifying unnoticed patterns in patients' behaviors and communications, extracting implications from their manifest contents, and generating unsubstantiated propositions regarding purported connections between current material and past behaviors and events. These efforts were understood to lead, at times, to superficially unconscious formulations, but the insights involved proved to be overintellectualized and emotionally unempowered.

Focus shifted to a more compelling, truly disguised set of unconscious meanings that were formulated based on the discovery that only narrative messages such as dreams and stories carry encoded meanings. It was found that first and foremost, these storied communications disguise adaptive responses to recent, currently active, traumatic triggering events. New techniques were developed to facilitate narrative expressions because it became clear that the conscious human mind is terrified of death-related traumas and that it therefore unconsciously perceives and encodes perceptions of many aspects of threatening external events—and that it does so far more often and importantly than any kind of inner need or wish. These traumatic incidents, expressed in both word and deed, are the root source of emotional dysfunctions. This thesis was amply validated unconsciously through patients' positive encoded narrative responses to adaptation-oriented interventions, which took form as trigger-decoded interpretations and ground-rule-securing efforts based on patients' encoded imagery.

There was a move, then, away from a listening process that primarily sought to formulate inner needs and wishes, one in

which intellectualizations as well as narratives were given equal weight communicatively because both lend themselves to inference-making. It was replaced by a reality centered mode of listening in which dreams and stories are properly understood to be the sole carriers of encoded, deep unconscious meanings. Critically, the change was from primarily generating formulations and interpretations of forbidden unconscious needs and fantasies to generating formulations of forbidding unconscious perceptions and experiences.

The manifest intellectualizations and speculations from patients that all but a few present-day analysts work with and from which, in like manner, they intellectually try to extract hidden meanings are single message expressions whose unconscious meanings are *implied but not encoded* in verbal communications. They are to be distinguished from narrative vehicles, which are double-message expressions in that they too have manifest meanings fraught with implications, but exclusively they also convey unconscious meanings that are neither directly stated nor implied, but are instead disguised in the manifest tale. The decoding of this level of meaning must be carried out in light of the *triggering event* that stimulated the deep unconscious processes involved in the interlude—the aforementioned use of *trigger decoding*. Aside from major traumas outside of therapy, the triggers for patients' unconscious perceptions and adaptive processing efforts, dreams and stories, tend to be constituted as their therapists' interventions—their efforts at managing the ground rules of treatment and responding behaviorally or verbally to patients' material and actions.

The key, clinically validated insight was that the emotion-processing mind has evolved primarily to respond to and encode unconscious perceptions of disturbing realities. This realization led to a dramatic shift in psychoanalytic understanding and in many aspects of therapeutic technique. Because threatening realities are the basic dangers for humans and the ultimate cause of emotional maladaptations (and creativity), trigger decoding is the only means we have at present for accessing the unconscious issues evoked by these traumas and resolving the conflicts and symptoms they cause.

Most noteworthy among the changes that ensued was a re-

jection of the function-based, structural model of ego, id, and superego as defining the most basic systems of the mind—such functions do exist, but they needed to be remapped and relocated. In its place, there was a return to the centrality of Freud's rejected level-of-awareness-based topographic model, greatly revised. The resultant map of the mind was built around the concept of an adaptive module—*the emotion-processing mind*—which has evolved mainly to cope with emotionally charged, traumatic events and the death anxieties that they evoke (Langs, 2004b, 2006). The updated model posits a two-system mental module in which each system has a distinctive set of features and operates in a relatively independent manner. This means that there are two very different ways that we, as humans, experience, remember, process, adapt to, communicate about, and respond to emotionally charged impingements, be they from other living beings, especially other humans, natural phenomena, or, secondarily, our own inner mental thoughts, feelings, and needs.

The *conscious system* operates on the basis of perceptions that register within awareness, which it then generally deals with directly and manifestly. This world of experience is captured through clinical work with the manifest contents and the evident implications of patients' narrative and nonnarrative, intellectualized communications. In contrast, the *deep unconscious system* operates on the basis of unconscious or subliminal perceptions that register and are processed outside of awareness throughout. This world of experience is captured by trigger decoding narrative images and associations to these images in light of the triggering events that have evoked them.

In response to traumatic triggering incidents, each system responds differently, often in ways that are diametrically opposed. Each recruits a particular set of relevant memories, coping strategies, knowledge-based resources, moral considerations, defenses, and the like. The conscious system responds to consciously registered challenges using direct reasoning, which, for reasons of defense and unconscious guilt, often is erratic, offbase, and self-defeating. In contrast, the deep unconscious system, which also operates with logic and understanding, comes up with adaptive solutions to its unconsciously perceived experiences that are remarkably wise, consistent within and between

individuals, and highly moral. But because these insights are conveyed through encoded or disguised imagery, they are not available for conscious adaptive responses. The proper use of trigger decoding is the only means we have to make use of the profound wisdom of this deep unconscious system of the mind.

Clinical studies assessing the responses of the two systems to the same disturbing triggering events allow us to compare and contrast their operations and to identify the basic features of each. On this basis, it has been found that conscious perceptions meet with a wall of defenses that block conscious registration of many disturbing incoming meanings and, as a result, the conscious mind suffers from many significant blind spots. Indeed, the conscious system makes abundant use of obliterating and denial-based defense in responding to entire traumatic events (much is simply missed) and to many of the most anxiety-provoking meanings of consciously recognized incidents that are harmful physically and/or psychologically. The use of trigger decoding makes this quite clear because these obliterated experiences and denied meanings are *perceived and registered unconsciously*, processed outside of awareness, and encoded in narrative vehicles.

An excessive use of denial is a fixed feature of the conscious system, one that has evolved in order to protect the conscious mind from overload and dysfunction that are likely to result from traumas large and small. The conscious mind is, then, first and foremost a self-protective, defensive, denial-prone system that is greatly impaired by its relative incapacity to deal with death and death anxiety. This extensive use of denial results in significant impairments in conscious intelligence and adaptive wisdom as compared to their deep unconscious counterparts. We are at our wisest when we are unaware of the traumatic triggering event to which we are responding, do not know its most troublesome meanings, fail to recognize the death-related threats involved, and have no conscious idea of the death anxieties we are experiencing. These unexpected limiting and self-defeating features of the conscious mind call for an adaptationist scenario that can provide reasons for their selective evolution and explain how they have affected psychoanalytic practice.

Conscious adaptive preferences tend to be highly individualized and greatly affected by personal experiences, especially

those that are traumatic and death-related. There are few universals or archetypes operating in the conscious realm, a discovery that helps to explain the pervasiveness of conflicting conscious opinions and beliefs when it come to matters of psychoanalytic technique, such as the optimal nature of interpretive efforts and the handling of the ground rules of analysis—for example, whether touching a patient or personal self-revelations by therapists are or are not appropriate and healing. Indeed, because of the absence of evolved archetypes and of a viable means of identifying the unconscious effects of therapists' interventions, there is no reliable arbitrator of conscious system debates and consensus is all but impossible to achieve.

A similar finding pertains to human morality: Conscious system morality and ethics are highly individualized and thus tend to vary from one person or group to another. Individual conscious moral standards tend to be changeable, and values are easily compromised and corrupted. Much of this arises from the conscious mind's desperate efforts to deny death by carrying out immoral, rule-breaking acts that are unconsciously designed to defy the fundamental rule of life, which is to the effect that life is inevitably followed by death. Deeply unconsciously, a therapist's handling of the ground rules of therapy proves to be the clearest expression of his or her morality and basic way of coping with death and its attendant anxieties—frame modifications are seen as immoral acts, while securing frames are viewed as moral.

Along different lines, fatefully, the enormous wisdom of the deep unconscious mind, much of it death-related, has only the slightest effect on the conscious mind and on its choices of action—wisdom that is encoded cannot be used as an adaptive resource. On the other hand, deep unconscious guilt and the predator death anxiety it evokes because of harm caused others has a pervasive, albeit unconscious influence on conscious thinking that leads to many self-punitive choices.

As for the deep unconscious system, its perceptions tend to be undefended and not impaired by denial. As a result, it develops a remarkable reservoir of adaptive wisdom that is both personally healing and considerate of the needs of others. The system operates largely on the basis of fundamental human archetypes, most of them involving the universal ways in which we

perceive, experience, and try to cope with death-related traumas. In addition, the system possesses a pristine, archetypal set of morals and ethics, and on that basis it unconsciously arranges for rewards for adherence to these tenets and self-punishments when they are violated.

It follows from these considerations that there are two fundamental modes of psychoanalysis and psychotherapy. The first mode is Freudian-derived, based on manifest communications and their implications, and conscious-system dominated. As such, it inherits all of the limitations of the conscious mind such as the excessive use of denial, the variability of therapeutic principles and a lack of consensus, an underdeveloped knowledge base, vulnerability to questionable morals and ethics—which is expressed in part in not adhering to the ideal, archetypal ground rules of therapy—and a series of other consequences derived from the in-built but unconscious fear of death and its attendant anxieties that is characteristic of the conscious mind. The second mode of therapy is adaptively oriented and based on triggering decoding, which is designed to define and provide access to deep unconscious experiences and adaptive responses. It is founded on the extraordinary adaptive wisdom of the deep unconscious system, a pristine set of moral principles reflected in securing the ideal ground rules of treatment, an ability to deal forthrightly and as effectively as possible with death and death anxiety, and a consistency that comes from the dominance of archetypal unconscious responses to traumatic experiences.

Much as the conscious and deep unconscious systems operate independently and on their own very different terms; there is a dramatic difference—and huge gulf—between the two modes of therapy that I am defining. One is based on an inherent and consciously unrecognized effort to deny the impact of death and unconscious death anxiety on the human psyche and its psychotherapy, while the other is centered on dealing with these issues as optimally as possible. Conscious evaluations of therapists' interventions by both patients and therapists tend to be defensive and unreliable; they often favor harmful interventions that serve both patient and therapist in denying death and in unconsciously arranging for punishment for the harm each has done to others within treatment and outside of it. In contrast, en-

coded deep unconscious evaluations of therapists' interventions are nondefensive and reliable, and they tend to serve the best interests of patient and therapist alike. Put another way, psychoanalytic experiences that are based on conscious thinking tend to obliterate the awareness of, and insight into, the essential unconscious sources of patients' emotional dysfunctions that are dealt with in analyses based on deep unconscious thinking and wisdom.

Conscious system forms of therapy owe their acceptance and popularity largely to the defenses against death anxiety that they offer to both patients and practitioners—defenses that their listening and formulating methods prevent them from recognizing. On the other hand, adaptive psychotherapy owes its unpopularity and general nonacceptance to the fact that, through the process of trigger decoding, it facilitates the much-dreaded but essential bringing into awareness of all that is unbearable in life for both patients and their therapists. It thereby facilitates the conscious working over and working through of the symptom-causing, death-related problems and anxieties that other therapies avoid, a type of work that is inherently dreaded by the conscious minds of both parties to treatment. Adaptive therapists alone know of these distinctions and of the gulf that separates their approach to therapy from other treatment modalities. The situation is reminiscent of Bishop Berkeley's remarkable story, *Flatland* (Abbott, 1884), in which geometrical creatures exist in a two-dimensional world that makes it impossible for them to experience or appreciate a world that exists in three dimensions. Similarly, it takes a leap of technique in respect to how a therapist listens to and formulates patients' behaviors and communications to enter the very different world of deep unconscious experience that is accessed by adaptive psychotherapy.

UNCONSCIOUS DEATH ANXIETY

Because death and death anxiety are the ultimate issues in human life and thus in its psychotherapy, the adaptive approach has introduced the concept of *power* into its listening process. The deep unconscious system deals solely with heavily charged emotional issues, and thus the emergence of *power themes* serves

as an indicator that the therapeutic work is touching on disturbing deep unconscious issues. Power is represented by images and themes in dreams and stories, and in the narrative associations to their elements, that allude to harm, injury, natural disasters, illness, death, and the like. Unless they have violent or harmful qualities, sexual themes do not fall into this class; most often they are invoked to deny or distract attention away from death-related triggering incidents and their ramifications.

The conscious awareness of death and of its future inevitability for all humans arose with language acquisition (Langs, 1996, 1997). The anxieties and dangers it posed then served as a crucial selection factor for the design of the emotion-processing mind—survival was favored by minds that, by design, coped well with these issues. Three forms of death anxiety materialized and each was associated with a distinctive set of challenges to survival and each had a major influence on the architecture and operations of this mental module. They were—and are:

Predatory death anxiety—the fear of harm from other living beings, especially other humans, and from natural disasters. The archetypal response entails a natural tendency to overreact to threat and an inclination to attack before being attacked.

Predator death anxiety—the conscious and especially unconscious guilt caused by harming others and the resultant need for punishment ultimately by death (usually in the form of some form of self-harm or suicide equivalent). This kind of anxiety promotes an unconscious need to act in ways that invite self-punishing attacks from others and that are inherently self-defeating and self-punishing.

Existential death anxiety—the fear of ultimate personal demise. This type of anxiety, which most often operates unconsciously, activates a wide variety of behaviors and thoughts that are unconsciously designed to deny death and a person's enormous vulnerability to harm. This denial-based orientation is the default position of the conscious system of the emotion-processing mind as it operates in both psychotherapy and everyday life.

Unmastered unconscious death anxiety is the root cause of the dysfunctions that are inherent in conscious system functioning. It also is the basis for the false premises and denial-based, consciously wrought errant techniques that Freud developed for

psychoanalysis and for the finding that they govern standard forms of psychotherapy to this very day. To understand the present state of the field, then, we need to look at the early life of Sigmund Freud to ascertain the likely traumatic events that unconsciously had the greatest influence on his theory and techniques of practice—both their valid insights and erroneous propositions.

FREUD'S EARLY TRAUMAS AND HIS CREATION OF PSYCHOANALYSIS

There is strong evidence that very early in his life Sigmund Freud was the unwitting victim of three major, secreted death-related traumas. The first involved uncertainties about the date of his birth and whether he was the illegitimate child of his mother, Amalie. The second entailed serious doubts about the identity of his biological father, and the third pertained to the relatively recent discovery that Jakob Freud, Sigmund's familial father, had kept secret the existence of a second wife, Rebecca, whom he had wedded before he married Amalie (his first wife had died of natural causes after she had borne Jakob two sons, Emanuelle and Philipp).

The birth registry and other official records in Freiberg where Freud was born list his date of birth as March 6, 1856, rather than May 6, 1856 (Balmary, 1979). Mainstream biographers have given the earlier date little or no credence; they think of it as a clerical error despite the several records on which it is given. Nevertheless, if Freud was in fact born on the earlier date, it would mean that his mother was pregnant when she married Jakob and that Freud was her bastard child. But in addition, whatever the correct date of his birth, there is another generally overlooked issue associated with Freud's entry into this world, namely, the question of who his biological father actually was. There are indications of this doubt, which Freud seems to have experienced and processed unconsciously, both in the known facts of his early life and in the encoded narrative material found in his writings. The two candidates are his half-brother, Philipp, a young man who was Amalie's age, and his identified father, Jakob, who was much older than Amalie, spent a lot of time away

from home, and may well have been a womanizer (Balmary, 1979).

As a child, Freud is known to have entertained the conscious belief that Philipp and his mother were having and had had an affair (Krull, 1979; Vitz, 1988). When Freud was 3 years old, his sister, Anna, was born; Freud was convinced that Philipp had fathered the child. Mainstream biographers have viewed these beliefs as innocuous childhood fantasies, but there is much to suggest that Freud was trying to deal with unconsciously perceived realities that ultimately pertained to the identity of his own father.

As for the death of Rebecca, which is explored in detail by Balmary (1979), there are indications that she may have killed herself by jumping in front of a train. Clues to his unconscious awareness of this incident can be found in Freud's writings. A most striking example is seen in Freud's letter to Fleiss, written in 1897, announcing his rejection of the seduction theory of neurosis and purported discovery that the Oedipus complex is the core issue in emotional life (letter 69, Freud, 1887–1902). Quite out of context, after mentioning that clinically the conscious insistently blocks the unconscious from directly entering awareness and alluding to Hamlet, Freud thinks of Rebecca, the biblical wife of Isaac, as being told to take off her gown; she is no longer a bride. The allusion is to Rebecca not being a virgin when she married Isaac. These passages seem to touch unconsciously on the murdered and replaced father who must be avenged; the death of Jakob's second wife, Rebecca, whose existence was kept secret from both Freud and the world at large; and the belief entertained by Freud that his mother was not a virgin when she married Jakob and that someone other than Jakob had deflowered (and impregnated?) her. The likelihood of Rebecca's having committed suicide by jumping in front of or from a train may well be linked to Freud's severe train phobia as an adult.

In one way or another, each of these traumas was death-related. In the first two, Freud's very existence was threatened. As a result, even though these beliefs, uncertainties, and incidents appear to have affected him unconsciously, Freud eventually and unknowingly was faced with a fundamental choice: Tol-

erate the death anxieties involved and seek the truth of these events in order to consciously process their effects on his life and work, or deny the existence of these traumas and, in so doing, deny the influence of reality on human life in general. Initially, Freud leaned toward the first solution, but he changed course after his father died, much to the detriment of the field he founded (Balmary, 1979).

The need to deny his own traumas, for which Freud held his father most accountable, had a profound influence on Freud's psychoanalytic thinking. His first, clinically grounded formulation was that neuroses are caused by parental seductions, of which Freud stressed the seduction of daughters by their fathers. But soon after the death of his father and following his inevitably flawed efforts at self-analysis, Freud rejected the trauma theory of neuroses in favor of a theory that stressed the role of forbidden, incestuous wishes in the child toward the parent of the opposite sex. The flight from reality to fantasy, from the present and future to the past, and from unconscious perceptions to unconscious wishes had begun. In this connection, the dream that Freud dreamt the night of Jakob Freud's funeral is pertinent. It was a most unusual double dream: "Thou shalt close the eye; thou shalt close the eyes." Two features of this dream stand out: first, that although only one father had died, Freud had two dreams and two sets of eyes to close; and second, that closing the eyes implies shutting off external reality and thus denying what exists in that realm.

Freud's shift of focus from reality to fantasy is indeed a closing of the eyes. It appears, then, that in order to survive the conflicts and anxieties evoked by the death of his father, Freud had to blind himself to the harm he had experienced from Jakob, a need that led to a more general denial of the ways in which damaging life events and harm from significant others cause neuroses. Given that human life is filled with unexpected and unbearable, unconsciously experienced death-related traumas, Freud's denial-based theory of the mind has had great appeal to both psychoanalysts and the general public largely because they share with him an intense need to deny death and its encumbrances. The psychoanalytic techniques that Freud evolved

were unconsciously crafted to buttress this denial, and they are at the heart of present-day mainstream practices.

Of the three traumas Freud suffered, the most pressing appears to have been the uncertainty as to who was his biological father. His unconscious working over of this issue is a major encoded theme in his writings (Langs, 2008). For the sake of brevity, I shall limit myself here to the two most striking works that have a bearing on this issue: his papers on the Oedipus myth (Freud, 1924, 1925), and his last major creative piece, *Moses and Monotheism* (Freud, 1939; Yerushalmi, 1991).

In seeking the basic archetypes of human life, both Freud's turn to Greek mythology rather than the Bible and his selection of the Oedipus myth as the most critical Greek myth appear to be arbitrary and thus driven by personal need and unresolved conflicts. Much the same applies to Freud's central interpretation of the Oedipus tale, namely, that it reflects the boy's wish to sleep with his mother and murder his rivalrous father.

Reexamined, the Oedipus myth has three central themes. The first involves the exciting incident of the myth in which Oedipus is told that, despite his belief to the contrary, the King and Queen of Corinth, who raised him and whom he believes to be his parents, are not his biological parents. Oedipus's resultant search for his biological parents evidently had special meaning for Freud; it is in keeping with the thesis that unconsciously he was convinced that the father who raised him was not his biological father and that he had two fathers—one in name, the other in fact.

The second major theme involves Oedipus's acquisition of uncommon wisdom, which enables him to solve the riddle of the Sphinx and to avoid death at her hands. The acquisition of divine wisdom is a fundamental archetype related to the basic question of the kind of knowledge base on which a person will live his or her life—and do psychotherapy as well. Whether to live by mundane wisdom alone or to acquire divine wisdom is the first question that Eve and Adam—and by extrapolation, all of humankind—must deal with and answer (Langs, 2008). In addition, in both the Greek myth and the Biblical tale, divine wisdom is associated with knowledge of death and the recognition of human mortality.

These complex but fundamental archetypal issues have their current expression in psychoanalysis in that therapists unknowingly are faced with this choice when they select a theoretical base and mode of treatment with which to carry out their therapeutic work. Mainstream therapists have chosen to work with mundane (conscious system) wisdom alone, while adaptive therapists work with both kinds of wisdom in that the secular equivalent of divine wisdom is to be found in the deep unconscious system. This means that only patients entering adaptive psychotherapy are offered the opportunity to work with and benefit from their own archetypal divine knowledge and its connections to death and human morality; this option is not as yet available to patients seen by nonadaptive therapists.

The third set of themes in the Oedipus myth involves death and death anxiety. There are eight acts of violence in the story, which includes murder, attempted murder, suicide, and acts of vengeance; the tale is replete with life-threatening external dangers and responsive death-related archetypes (Langs, 2008). In this light, Freud's reading of the myth in terms of forbidden inner wishes pertaining to sexuality and incest speaks for an intense need to deny the myth's overwhelming representations of reality, assault, and death.

As for *Moses and Monotheism* (Freud, 1939), which Freud saw as a kind of deathbed confession (Balmary, 1979), the key theme in the book—that the father of the Jews was not a Jew—was based on highly questionable, repudiated historical evidence. Freud's insistence on developing this thesis suggests that he continued to work over and was adversely affected by the unresolved issue of his true origins to the very end of his life. In this connection, it is noteworthy that Freud believed that Shakespeare did not write the plays attributed to him and that Freud's first paper on the Moses of Michelangelo (Freud, 1914) was written under a pseudonym, the only instance of its kind in his writings. Being deceived by one's father who is an outsider and an intruder and whom you wish to murder is, then, Freud's last psychoanalytic pronouncement, and it appears to sum up the central problem in his personal life. It also helps us to understand why Freud did not believe in God and rejected religion as a proper subject for psychoanalytic study.

The power and complexity of the traumas that Freud suffered, which touched on his very existence, evidently were so anxiety-provoking that they were beyond conscious registration and mastery. Even so, despite ultimately opting for a denial-based approach to human psychology and the techniques of psychoanalysis, Freud was able to bring the idea of unconscious processes to the world at large and to initiate a field of endeavor that attracted many followers—largely, however, because they shared with him the evolved human need to deny death. Psychoanalysis evidently could see the light of day only if it was born with a soul of denial. It is humbling to realize that three likely traumas in the life of Sigmund Freud over which he had no control set back our understanding of the human mind and the treatment of its dysfunctions for more than 100 years. As a lesson for all time, Freud's story calls on therapists of all persuasions to examine their own death-related histories as part of an effort to discover through self-processing and trigger decoding (Langs, 1993) the deep unconscious effects that these events had on their own professional choices—and personal lives as well.

DIFFERENCES IN TECHNIQUE

Returning now to matters of psychoanalytic technique, critical differences exist between the two modes of psychoanalysis that I have been discussing. They arise mainly as a result of the distinctive features of the adaptive listening, formulating, and intervening processes. As noted, working adaptively requires the use of a particular way of attending to and understanding patients' material and therapists' own interventions. These efforts bring both patients and therapists into a world of experience that is very different from the world defined through conscious experience. This fact makes it all the more difficult for standard analysts to appreciate the adaptive position and its principles. I therefore shall characterize the differences involved in the two modes of treatment by describing some of the unique features of the practice of adaptive psychotherapy that I have not presented as yet.

The adaptive therapist makes use of the *fundamental rule* by advising patients to say whatever comes to mind—that is, to free

associate—without restriction. But there is as well a supplementary set of rules or advisories that are invoked to enhance access to deep unconscious experiences though patients' communication of encoded narrative expressions. Thus, patients are asked to begin each session with a brief comment about matters of concern to them so as to identify their immediate emotional issues, but then they are advised to describe a recent dream—one they had since the previous session—or to make up a fictional story if they do not recall a dream. In addition, a *rule of guided associations* is invoked in that patients are asked to associate to the elements of their dream or story by recalling and retelling (narrating) incidents that these elements bring to mind—events from their own lives (which is the usual domain of these recollections) or incidents they have heard or learned about from some outside source.

The rationale for these new procedures lies with the finding that, left to their own devices, patients defensively tend to avoid narrative communications and to intellectualize and analyze, rather than narrate in the course of saying what spontaneously comes to their conscious minds. If they report a dream, they are inclined to then make intellectualized comments about its contents and to offer consciously wrought interpretations of its meanings, offerings that are of doubtful accuracy and of limited, if any, value to the process of emotional healing.

This bent toward intellectualizing is a manifestation of the tendency of the conscious system of the emotion-processing mind to avoid and deny deep unconscious perceptions and adaptive processing efforts that deal with disturbing death-related realities. The need therefore is to help patients generate narrative pools of powerful themes that can be linked to triggering events within, and more rarely outside of, therapy. The importance of having patients generate reality-based, narrative associations to imagined dream elements lies with the discovery that unconsciously dream images are selected and fashioned from real incidents in the past that capture and reflect patients' unconscious experiences of current triggering events. In essence, then, dreams are created based on, and serve as markers for, past realities and traumas that are pertinent to current realities and traumas.

There is another feature of adaptive psychotherapy that is

designed to help overcome the massive resistances that the conscious mind erects to defend against the expression of deep unconscious perceptions of death-related incidents within and outside of therapy. While adaptive psychotherapy can be carried out in a limited and reasonably effective manner in a 45- or 50-minute hour, *the ideal adaptive session lasts 90 minutes*. Extended sessions are necessary to provide the time needed for the therapeutic work that must be carried out in order to overcome the resistances set up by the conscious minds of every patient who engages in the adaptive mode of treatment and to allow core issues to emerge. In like manner, the extra times gives adaptive therapists the time they need to resolve their own resistances against entering the deep unconscious realm of experience. Both parties to adaptive psychotherapies struggle against the evolved tendency to consciously obliterate and thereby miss a key triggering-event or to not recognize the trigger evoked implications of a theme or image.

The deep unconscious mind is severely divided when it comes to expressing encoded unconscious perceptions of the anxiety-provoking meanings of current traumas, especially when the perceptions touch on the early and sometimes later-day unresolved death-related traumas that have derailed a patient's life. Both within sessions and in their sequence from one session to the next, patients alternate between revelation and concealment. The latter is carried out largely through the failure to recognize an actively traumatic triggering event—the more threatening it is, the more likely it will not be mentioned consciously—as well as through the suppression of meaningful encoded images and through direct, heavily rationalized, unjustified, diversionary attacks on the therapist and therapeutic process. The 50-minute hour simply is not long enough to develop and deal with these resistances and a full set of powerful and frame-related narratives that encode patients' deep unconscious experiences of the traumas they have created or endured within and outside of their therapies. It can be seen, then, that the Freudian models of psychoanalysis and psychotherapy unwittingly offer patients a time-based, basic resistance to entering the death-related, deep unconscious realm of experience.

In this connection, it has been found that there is a single

archetypal path from a manifest dream to a deep unconscious insight: The report of a dream or made-up story; narrative guided association to its elements; the identification of the most active and compelling triggers that have evoked the emergent themes; the therapist's trigger-decoded interpretation, which explains the unconscious basis for the patient's current emotional difficulties and/or a frame-securing intervention that sets the stage for further deep unconscious insight for the patient; and finally, the encoded, unconscious, narrative-based validation by the patient of the therapist's intervention. It is well to appreciate that both patients and therapists are naturally programmed through the evolution of the emotion-processing mind to resist walking down this ultimately terrifying, but deeply healing pathway. Much adaptive therapeutic work is needed to do so.

In utilizing the 90-minute hour, it has proven to be of enormous value to turn over the first 40 minutes of these sessions entirely to the patient, during which time the therapist is totally silent (Langs, 1993). Patients are taught the practical features of the above-mentioned road map, and they are given the opportunity to make that journey on their own during the opening minutes of each session. This gives their therapists a unique opportunity to observe the mind in action, as it moves toward defensiveness or insight—or both. Remarkably, the most basic observation in this regard is that the conscious minds of patients are virtually incapable of successfully carrying out this process to its complete fulfillment—a finding that seems applicable to many psychotherapists as well. Every patient has a relatively immutable set of defenses and communicative resistances against carrying this journey forward. Indeed, no matter how much insight is offered to them as to the nature of their resistances and their unconscious sources, they automatically invoke these communicative defenses in session after session. It is left to the therapist, during the 50 minutes in which he or she is active, to work with the patient, using a Socratic teaching style, to identify these resistances, understand their immediate deep unconscious sources in reactions to triggering events, and modify their use. This work opens the path to patients' communicating fresh and meaningful narratives, the identification of the most pertinent active triggers, and the interpretation of the resultant material, and, in addition, the

securing of any ground rule of therapy in need of such action (Langs, 2004b, 2006).

Clearly, I am describing a way of working with patients and conducting an analysis or psychotherapy that is very different from common practice today. And even though the adaptive process is narrowly defined, it is all but impossible for patients to carry it through from beginning to end without the help of an adaptive psychotherapist, and it is extremely difficult for therapists to engage in as well. Yet despite the strict guidelines, without which achieving deep insight is impossible, openness and intuitiveness are needed in dealing with every aspect of the process—all of it going against the grain of therapists' own natural defenses. Doing adaptive psychotherapy is an unnatural effort, yet it is the only presently known means of accessing the world of deep unconscious experience on which human madness is based—and can be insightfully resolved.

CONCLUDING COMMENTS

I shall close this article with a few comments on unconscious death anxiety, the facet of emotional life that is the root cause of both emotional disorders and human creativity. By and large, there is considerable survival value for humans who experience much of their death anxiety unconsciously rather than consciously—excessive conscious death anxiety is likely to seriously disrupt adaptive functioning. The problem lies with the finding that the various ways that humans deny death and obliterate the anxieties it evokes also tend to disrupt conscious efforts at adaptation. Like all humans, patients and therapists are between a rock and hard place when these issues are activated in the course of a therapy experience. As a result, humans invoke many mad death-related conscious beliefs and act in strikingly mad ways under the sway of unconscious death anxiety. We are a long way from taming this beast of burden; the pervasiveness of the denial of death that characterizes the psychoanalytic literature is an indication of how far mainstream analysts have to go before they take on and begin to resolve this most critical issue.

Deep unconscious death anxiety is reflected in encoded death-related themes that are displaced from the triggering

events that have evoked the anxiety. Its presence cannot be detected straight on; it can be discerned solely through the process of trigger decoding. It is an experience that is very different from conscious death anxiety and the panic attacks that often are linked to manifest fears of death or dying. These conscious experiences tend to be triggered by strong, evident dangers, while a great deal of unconscious death anxiety is triggered by events that often are not consciously recognized as death-related.

Unconscious death anxiety is a universal experience, and once an awareness of the finality of death has set in, which occurs around the fourth year of age, it is with us in some form just about every minute of our lives. It is the most powerful unconscious determinant of emotion-relevant human behavior, adaptive and maladaptive. In narrative forms of adaptive psychotherapy, patients tend to generate death-related themes early in their sessions, and a session without such themes is extremely rare; as a rule, these sessions are an expression of an extreme form of communicative resistances usually caused by an overwhelming death-related experience. Often, the death-related themes, which may allude to death itself, serious injury and illness, suicide attempts, and the like, are scattered in the patients' associations—a tale of death here, one of injury there, a mention of a suicide elsewhere. It is the task of both the patient and the therapist to weave these allusions together into a story that describes how the patient is perceiving and trying to cope with a measure of death anxiety that has been activated by an identified traumatic triggering event. Here too therapists are faced with considerable difficulties largely because, with few exceptions, the traumatic intervention that the patient is working over has been made by the same therapist who is trying to trigger decode the imagery—it is much like a person's trying to dig up the evidence that shows he or she is guilty of murder.

On the patients' side, activated traumas related to harm that they have done to others—for example, through accidents, miscarriages, abortions, and other causes of physical or psychological harm—evoke strong self-punitive, death-related imagery and equally strong resistances against properly trigger decoding these themes, which often are brutally grim and involve encoded suicidal images or conscious thoughts of suicide. These are very

arduous issues for the parties to therapy to deal with, all the more so when, as often is the case, they touch on personal traumas experienced or created by the therapist, which should, of course, not be revealed to the patient.

This brings me to an aspect of unconscious death anxiety that has been the source of considerable confusion and misunderstanding: the connection between this nonconscious form of anxiety and the ground rules, framework, and boundaries of the therapeutic situation. First, it needs to be emphasized that the conscious and the deep unconscious views and experiences of the ground rules of therapy and analysis are dramatically different. This has made it all but impossible for mainstream therapists to appreciate the unconscious impact that the ground rules and conditions of therapy exert on both themselves and their patients, and on the treatment experience itself. The conscious mind tends to be cavalier about the ground rules of therapy and to advocate flexibility in ways that are unconsciously experienced as harmful to all concerned. Cognitively, this arises largely because on the conscious level of experience there are no universal or archetypal ground rules; all manner of variations are endorsed and accepted by both parties to treatment. As a result, the conscious mind is inclined to seek or support all manner of individually crafted rules of therapy, including many that seem patently harmful to a neutral observer. Much of this arises because the secured frame, which is inherently safe and supportive for both parties to therapy, also evokes severe forms of death anxiety, especially of the existential variety. In addition, the conscious mind is unconsciously inclined toward invoking or accepting harmful rules of therapy and boundary violations that serve to punish the patient for harm caused others—and at times, the therapist as well. The conscious mind cannot be trusted when it comes to establishing or evaluating the ground rules of psychotherapy.

Matters are quite different on the deep unconscious level of experience. The deep unconscious mind universally advocates the use of an ideal, archetypal, secured, inherently enhancing set of rules, frames, and boundaries for a psychotherapeutic experience. This includes a set time, place, frequency, and fee for the sessions with the patient fully responsible for the fee for all

scheduled hours; the patient engaging in both free and guided associating; total privacy and confidentiality; the relative anonymity of the therapist with no deliberate self-revelations; the absence of physical contact; the therapist's use of trigger-decoded interpretations and frame-securing interventions based on decoding the patient's narrative material; and a host of other implied rules that ensure the boundaries and safety of both patient and therapist. My expanded supervisory work has shown that this archetypal set of ground rules finds universal support in deep unconscious preferences and thinking throughout the world.

The differences between the conscious and the deep unconscious experiences and predilections in regard to the ground rules of therapy hinge on the close relationship between the three forms of unconsciously experienced death anxiety and the ground rules of treatment—a relationship that only the deep unconscious mind recognizes and works over. The disconnect between the conscious and the deep unconscious systems of the emotion-processing mind also plays a notable role in this regard, largely because the conscious mind, which orchestrates human choices and behaviors, is relatively unaffected by deep unconscious perceptions and the system's wise and effective adaptive recommendations. Thus, despite the harm done, the denial of death that is inherent to departures from the archetypal frame makes them quite appealing to both patients and therapists. Nature has evolved a human emotion-processing mind with many self-damaging features, almost all of them due to our inability to develop effective ways of coming to terms with our ultimate fate and the unmastered existential death anxieties this causes us—anxieties that are activated by secured frames. This means that the safest, most healing conditions for a therapeutic experience that therapists can offer their patients evoke the strongest death anxieties that both parties to therapy can experience. This finding accounts for the strong conscious need to modify frames regardless of the cost in unconsciously caused emotional difficulties for both patient and therapist. The conscious mind has little insight into the benefits that accrue to secured frames and little or no faith that it can cope with the death anxieties that they evoke.

The human mind readily trades existential death anxiety for both its predator and predatory forms. Thus, departures from the ideal frame—so-called *frame modifications*—evoke unconscious predator death anxiety, deep unconscious guilt, and the need for punishment in the perpetrator, who usually is the therapist, while the victim of the modification, who usually is the patient, experiences unconscious predatory death anxiety. Such are the ways of the human mind as viewed with both humility and concern through the lens of the adaptive approach.

REFERENCES

Abbott, E. (1884). *Flatland*. New York: New American Library, 1984.

Balmary, M. (1979). *Psychoanalyzing psychoanalysis*. Baltimore, MD: Johns Hopkins University Press, 1982.

Dobzhansky, T. (1973). Nothing in biology makes sense except in light of evolution. *The American Biology Teacher, 35*:125–129.

Freud, S. (1887–1902). *The origins of psychoanalysis: Letters to Wilhelm Fliess, drafts and notes*. (M. Bonaparte, A. Freud, & E. Kris, Eds., Letter No. 69, 1897, pp. 215–218). New York: Basic Books, 1954.

_____ (1912). On the universal tendency to debasement in the sphere of love. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud*. 24 vols. London: Hogarth Press, 1957–1974. *11*:177–190.

_____ (1914). The Moses of Michelangelo. *Standard ed., 13*:211–236.

_____ (1917). A difficulty in the path of psycho-analysis. *Standard ed., 17*:135–144.

_____ (1924). The dissolution of the Oedipus complex. *Standard ed., 19*:173–179.

_____ (1925). Some psychical consequences of the anatomical distinctions between the sexes. *Standard ed., 19*:243–258.

_____ (1939). Moses and monotheism: Three essays. *Standard ed., 23*:3–137.

Gay, P. (1988). *Freud: A life for our time*. New York: Norton.

Krull, M. (1979). *Freud and his father*. New York: Norton, 1986.

Kuhn, T. (1962). *The structure of scientific revolutions*. Chicago: Chicago University Press.

Langs, R. (1993). *Empowered psychotherapy*. London: Karnac Books.

_____ (1995). *Clinical practice and the architecture of the mind*. London: Karnac Books.

_____ (1996). *The evolution of the emotion-processing mind, with an introduction to mental Darwinism*. London: Karnac Books.

_____ (1997). *Death anxiety and clinical practice*. London: Karnac Books.

_____ (2004a). Death anxiety and the emotion-processing mind. *Psychoanalytic Psychology, 21*:31–53.

_____ (2004b). *Fundamentals of adaptive psychotherapy and counseling*. London: Palgrave-Macmillan.

_____ (2006). *Love and death in psychotherapy*. London: Palgrave-Macmillan.
_____ (2008). *Beyond Yahweh and Jesus: Bringing death's wisdom to faith, spirituality, and psychoanalysis*. Latham, MD: Roman & Littlefield.
_____, Badalamenti, A., & Thomson, L. (1996). *The cosmic circle: The unification of mind, matter and energy*. Brooklyn, NY: Alliance Publishing.
Vitz, P. (1988). *Sigmund Freud's Christian unconscious*. New York: Guilford Press.
Yerushalmi, Y. (1991). *Freud's Moses: Judaism terminable and interminable*. New Haven, CT: Yale University Press.

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