My focus throughout this book has been on the many ways in which contemporary relational approaches have viewed mutuality and inter-subjectivity as central to both the theory and the practice of psychoanalysis. I have stressed mutuality and relationship (supposedly “feminine” values) because psychoanalysis and our culture at large have so consistently privileged individuality and autonomy (which our culture marks as “masculine” attributes). Nevertheless, I have continually argued that the conceptualization of the analytic situation that emphasizes mutuality needs to be balanced in practice by a recognition of the inevitability of asymmetry, and that the principle of mutual regulation must be held in tension with self-regulation or autonomy. In the discussion of one- and two-person psychologies (in Chapter 2) we reviewed Bakan's (1966) distinction between “communion” and “agency” as well as Buber’s (1947) differentiation between the “originator instinct” and the “instinct for communion” and suggested that relational theory attempts to maintain the pull between these two forces.

In this chapter, I trace the origins of contemporary relational theory back to the early contributions of two psychoanalytic pioneers, Sándor Ferenczi and Otto Rank, whose clinical ideas balanced each other in terms of two complementary postulates of autonomy and mutuality, agency and communion. I am highlighting these two creative trailblazers because I believe that together their contributions represent the nucleus of relational theory. A comprehensive history of the development of relational ideas would, however, not only have to look at how these were embedded in aspects of Freud’s own work, but also would have to take into account the important contributions of Adler, Jung, Abraham, Reich, and others. Needless to say, a study such as this would represent a book in itself. Here I will limit my review only to
those aspects of Ferenczi’s and Rank’s work that is directly relevant to the dialectical principles of mutuality and autonomy.

While both Ferenczi and Rank proposed fundamentally relational theories, Ferenczi’s work leaned in the direction of mutuality, relationship, and communion whereas Rank’s theory was more heavily weighted toward autonomy, individuation, and agency. Ferenczi focused on the reciprocal processes operating between self and other; Rank’s theory had to do with the emergence of the self within a relational context. (Keep in mind the development of relational theory that was reviewed in Chapters 1 and 2.)

Recall that one of the unique features of Mitchell’s (1988a) relational approach is his effort to bring together the contributions of a variety of relational theorists that heretofore were independent and isolated. Some of these theorists, like Fairbairn, tended to focus on the object; others, like Winnicott and Kohut, on the self; and still others like Sullivan, on the interactions between self and object. One can describe each of their contributions as broadly relational. As Bacal (1995b) has pointed out, “Object relations theory and self psychology are both misnomers—misnomers of omission” (p. 406). Object relations theories, while placing the object at the center of investigation, are also implicitly psychologies of the self as constituted by these internal objects; whereas self psychology, while highlighting the psychology of the self, is also implicitly a theory of the object relationship that affirms, sustains, disrupts, and repairs the self. Similarly, Ferenczi’s theory of the mutuality of relationship is also implicitly a psychology of the self, a self that may be split, fragmented, or dissociated owing to trauma and that can be healed, ultimately, only through love. Rank’s theory of the birth of the self is also a psychology of relationship, one that provides the necessary affirmation for the strengthening of the individual’s will. The two emphases need, balance, and compensate for each other.

SÁNDOR FERENCZI AND MUTUAL ANALYSIS

The sudden emergence in modern psychoanalysis of portions of an earlier technique and theory should not dismay us; it merely reminds us that, so far, no single advance has been made in analysis which has had to be entirely discarded as useless, and that we must constantly be prepared to find new veins of gold in temporarily abandoned workings [Ferenczi, 1929, p. 120].

As he wrote these words, Sándor Ferenczi could have had no idea how prophetic they would be with respect to his own work! Sixty years after his clinical experiments with countertransference disclosures, we return to his work “to find new veins of gold in temporarily abandoned workings.” Ferenczi’s clinical experiments with mutuality, as well as his theoretical revisions regarding trauma, are among the most controversial innovations in the history of psychoanalysis. His therapeutic investigations led to theoretical, clinical, and technical discoveries concerning trauma, dissociation, the use of countertransference, and enactment within the transference—countertransference matrix. These still controversial ideas continue to occupy center stage in contemporary debates about psychoanalysis and psychoanalytic technique. Ferenczi’s work with countertransference disclosure, which culminated in “mutual analysis,” remains to this day unparalleled in its boldness.¹

In the writings of recent scholars, Ferenczi emerges as a complex figure, hero, flawed hero, man of excesses, courageous innovator, “enfant terrible,” dissident, madman, passionate follower, and friend to classical analysis and to Freud. In some lights he is the prescient innovator of all modern trends, champion of egalitarianism and mutuality, as well as crusader for the recognition of child abuse and trauma. For others, he is the precursor; he sowed the fascinating seeds that have flourished and evolved within the main body of psychoanalytic thought. Ferenczi’s contributions to the early history of the psychoanalytic movement were second only to Freud’s. He was a central organizer of the movement, a leading spokesperson and lecturer, and a theoretical and clinical contributor of the first rank. He was the founder of the International Psychoanalytical Association, founder of the Budapest Psychoanalytical Association, the first Professor of Psychoanalysis at a university (The University of Budapest), and organizer of the International Journal of PsychoAnalysis. Above all else, Ferenczi was widely regarded as the leading psychoanalytic clinician of his day, “the specialist in peculiarly difficult cases” who had a “kind of fanatical belief in the efficacy of depth-psychology” (Ferenczi, 1931, p. 128). Freud (1937) himself memorialized Ferenczi as a “master of analysis” (p. 230) who “made all analysts into his pupils” (Freud, 1933, p. 228).

¹For an excellent chronological review of Ferenczi’s contributions to psychoanalysis, see Lum (1988a, b). For a broad introduction to the range of his contributions as they anticipated current controversies in psychoanalysis, see Aron and Harris (1993) and Stanton (1991). For a detailed discussion of the origins of Ferenczi’s experiments with mutuality in terms of his own character and personality, see Aron, (1995b). For an earlier study of Ferenczi, Harold Searles, and relational theory, see Aron (1992a). For more on mutual analysis, see Ragen and Aron (1993). For a discussion of Ferenczi’s contributions in the light of the accusations of his mental disturbance, see Dupont (1988) and the exchange of views between Tabin (1993, 1995) and Aron and Frankel (1994, 1995). For a discussion of Ferenczi as a precursor to postmodernism, see Harris and Aron (in press).
For decades much of Ferenczi’s work was suppressed, and he was dismissed by mainstream psychoanalysts, disregarded because of his radical clinical experiments, because of his revival of interest in the etiological importance of external trauma, and because he was perceived as encouraging dangerous regressions in his patients and was attempting to cure them with love. All these criticisms were reinforced with personal aspersions on his character and accusations that he had mentally deteriorated and even gone mad in the final years of his life, at the height of his clinical experimentation and disputes with Freud. Balint (1968) argued that “the historic event of the disagreement between Freud and Ferenczi acted as a trauma on the analytical world” (p. 152). One of the great tragedies in the history of psychoanalysis was the suppression for more than half a century of Ferenczi’s clinical experiments, his Clinical Diary, (Ferenczi, 1932) as well as of the Freud-Ferenczi correspondence (Brabant et al., 1993). These have been translated into English and published only in the past few years.

Ferenczi’s work is largely concerned with the heart of the analytic situation, the relationship between patient and analyst. His discoveries were precisely in those areas that are receiving the most lively attention among current psychoanalytic theorists and practitioners. In many respects, in his disagreements and debates with Freud, Ferenczi set the agenda for almost all the current controversies on the psychoanalytic scene: emphasis on technique versus metapsychology; experience versus insight; subjectivity versus theory; empathy versus interpretation; a “two-person psychology” versus a “one-person psychology.”

While Ferenczi’s clinical experiments with “mutual analysis” did not actually begin until the late 1920s, Ferenczi had been championing principles of interpersonal engagement and mutuality for decades. He argued idealistically that, once people really understood the workings of their unconscious minds, their world views would undergo significant modifications in the direction of increased openness, honesty, and directness.

The final consequence of such insight—when it is present in two people—is that they are not ashamed in front of each other, keep nothing secret, tell each other the truth without risk of insult or in the certain hope that within the truth there can be no lasting insult [Freud to Ferenczi, October 3, 1910, Brabant et al., 1993, p. 220].

Ferenczi’s enthusiasm about the role of mutuality in psychoanalysis was not simply the product of his later technical experiments with a certain type of difficult case. Nor were they simply the remnants of unresolved transference feelings deriving from his brief analysis with Freud. Rather, Ferenczi’s romantic longing for mutuality, his thirst for truth, his idealized search for openness, emotional exchange, closeness, and intimacy, all were part of his character structure and became incorporated into his psychoanalytic world view.

A number of clinical pathways converged in Ferenczi’s work to lead him toward the end of his life to increasing experimentation with countertransference disclosure as a facilitating clinical technique. One of these pathways was his work exploring the traumatic factors in the pathogenesis of neurosis and character disorders. He discovered that the typical “anonymous” and “neutral” posture of analysts toward their patients repeated elements of the parent–child relationship that had led to the patients’ illnesses. Ferenczi saw the polite aloofness of the analyst as a form of professional hypocrisy that kept both the patient’s criticism of the analyst repressed and the analyst’s true feelings toward the patient masked, although nevertheless felt by the patient. The analyst’s emotional inaccessibility and insincerity repeated that of the traumatized patients’ parents. The trauma could not be worked through unless the patients reworked it in relationships in which they were confident of the other’s emotional honesty, sincerity and accessibility. In Ferenczi’s (1933) view, it was the confidence in the fundamental honesty of the relationship that constituted the curative difference between the present and the traumatic past.

Along with his work on trauma, experimentation with the principle of relaxation or passivity was another route by which Ferenczi arrived at what he saw to be the need for countertransference disclosure or countertransference interpretations. He found that patients reacted to his passive permissiveness with increasing demands on, and abuse of, his tolerance and patience. Ferenczi eventually discerned that the patients’ escalation was an artifact created by the unnaturalness of his passivity. The escalation abated when Ferenczi expressed opposition, bringing patients into a more beneficial, real relationship in which they had to take into account the needs and sensitivities of the other.

Ferenczi’s experimentation with “mutual analysis” emerged from a fundamental conviction, which progressively developed over the course of his work, about the centrality of experience in relationship. For Ferenczi, the roots of pathology lay in early relationships, and new experience in relationship was essential for healing. This idea was later to become the very basis for all interpersonal approaches to psychoanalysis. Ferenczi and Rank (1924) challenged the prevailing notion that remembering was the chief aim of analytic work, whereas repetition was a sign of resistance. In contrast, they maintained, repetition was essential. They proposed that, for cure to occur, what they called a “phase of experience” had to precede the customary “phase of understanding.” In this expanded conceptualization of treatment, it is the task of the analyst directly to provoke a reexperiencing of early conflict.
and trauma, an actual reliving, in the relationship with the analyst. In their view, the analyst's knowledge of universal fundamental early experiences enables him or her "to intervene at the right place, and in the requisite degree" (p. 56) so as to provoke this essential reliving. It is only after reliving is accomplished that the phase of understanding can occur.

Then the analyst's task becomes one of interpretation and reconstruction, fostering memory and insight on the part of the patient. The efficacy of interpretation and the healing power of remembering and insight were thought to rest on the ability of the analyst and the patient together to engage in the reliving of the patient's early relationships. Ferenczi and Rank believed that it was the affective relation between analyst and patient that allowed the reliving to unfold and that the reliving further forged the affective bond. In consequence, they concluded that "this kind of therapy consists... far more in experience than in the factor of enlightenment" (p. 56).

This conviction about the essential role of experience for the patient inevitably led Ferenczi to rethink the nature of the analyst's position and activity in the analytic relationship. In his eyes, analysis was first and foremost a relationship. In the experiential reliving of the past, a new present is both found and created—a new self, a new other, and new possibilities for what can occur internally and externally between self and other.

Pursuing this avenue of thought, Ferenczi became increasingly convinced that the reality of the person of the analyst had a decisive impact on the patient and thus had to be reckoned with in the relationship. To ignore it was a pretense and to try to structure the relationship to eliminate it was a contrivance that patients might overly go along with even though they were nevertheless affected by it. Ferenczi grew to have a sense of conviction about the importance of bringing the analyst's own reactions to the patient into the work. He contended that not doing so repeated the repression, denial, and inaccessibility of the parent, which had been crucial elements in the originally pathogenic situation. He stated that keeping one's reactions secret "makes the patient distrustful" as he or she "detects from the little gestures (forms of greeting, handshake, tone of voice, degree of animation, etc.) the presence of affects, but cannot gauge their quality or importance" (Ferenczi, 1932, p. 11). Secrecy leaves the patient mystified, whereas disclosure allows the patient to know where he or she stands in the relationship and, on the basis of the trust which that generates, to enter into new considerations of self and other.

Inevitably, the growing openness and naturalness that Ferenczi's approach evoked created an atmosphere in which patients felt free to see and speak about his limitations. Patients began to challenge him on what they saw to be countertransference obstacles in his treatment with them. One patient, Elizabeth Severn, identified in the Clinical Diary (Ferenczi, 1932) as RN, insisted that she should have the right to analyze Ferenczi because his unresolved conflicts impeded her treatment. And so, in his inimitable spirit of openness, Ferenczi began the experiment of "mutual analysis." I will soon examine the case of RN to determine what was learned from this clinical experiment, what was useful, and what went wrong.

In his Clinical Diary, Ferenczi (1932) provides fragments about the specific reasons for which mutual analysis was proposed. He states that the first patient who wanted to analyze him (RN) wished to do so because she "did not have the impression of me that I was completely harmless, that is to say, full of understanding. The patient sensed unconscious resistance and obstacles in me" (p. 73). In a more dramatic entry, Ferenczi states that RN insisted on mutual analysis "as the only protective measure against the inclination, perceived in me, to kill or torture patients" (p. 11). In yet another note, Ferenczi reveals that mutual analysis was initially undertaken in response to the patient's complaints that he lacked "any real empathy or compassion," that he was "emotionally dead." Ferenczi believed that his countertransference did, in fact, confirm the truth of these criticisms. The analysis revealed to Ferenczi that "in my case infantile aggressiveness and a refusal of love toward my mother became displaced onto the patients... Instead of feeling with the heart, I feel with my head. Head and thought replace heart and libido" (p. 86).

Ferenczi considered his "own analysis a resource for the analysand. The analysand was to remain the main subject" (p. 71). With that guiding principle in mind, the question of mutual analysis occupied Ferenczi's thinking until the end. His initial fears of it gave way to much enthusiasm. He entertained doubts and questions. He expanded the scope of mutual analysis to exclude nothing and then drew back to a more limited expance.

Throughout his experimentation with mutual analysis, he was aware of its inherent difficulties. He was concerned that patients would turn their focus away from themselves and search for complexes in the analyst as a way of avoiding their own problems. He also worried that his own tendency to find fault with himself would divert attention from the patient and would enact a masochistic submission. He raised questions about the problems of confidentiality and discretion as well as the impossibility of being analyzed by every patient. Aware that patients' tolerance for disclosure would grow over time, he wondered about issues of timing.
Although Ferenczi was quite open to his own as well as others’ evaluations of his explorations, he also initiated his experiments without much critical reserve. He frequently reversed stands and often took extreme positions throughout his work. He characterized himself as having a “tendency to risk even what is most difficult, and then to find motives for having done so” (p. 73). At the time of these experiments with mutual analysis (on September 15, 1931) Ferenczi wrote to Freud regarding his own tendency to go to the extremes:

In my usual manner, I do not shy away from drawing out their conclusions to the furthest extent possible—often to the point where I lead myself “ad absurdum.” But this doesn’t discourage me. I seek advances by new routes, often radically opposed, and I still hope that one day I shall end up finding the true path.

All this sounds very mystical: please don’t be alarmed by this. As far as I can judge myself, I do not overstep (or only seldom) the limits of normality. It’s true that I’m often wrong, but I’m not rigid in my prejudices. [Ferenczi, 1932, pp. xiv–xv].

One can see in his Clinical Diary how he wrestled with ideas about mutual analysis to the very end of his life. Ferenczi’s ambivalence and vacillation concerning mutual analysis are highlighted by three late entries in his diary. On June 3, 1932, he wrote, Mutual analysis: only a last resort! Proper analysis by a stranger, without any obligation, would be better (p. 113). Only two weeks later, on June 18, he stated:

It is true that as a doctor one is tired, irritable, somewhat patronizing, and now and then one sacrifices the patient’s interests to one’s own curiosity; or even half-unconsciously makes covert use of the opportunity to give vent to purely personal aggression and cruelty. Such mistakes cannot be avoided by anyone and in any of the cases, but one must (a) be aware of it, (b) taking hints from the patients, admit these errors to oneself and to the patients.

But such confessions, however often they may be repeated, will not get us any further if we (a) do not resolve to come to a radical understanding through mutual analysis, (b) as a consequence of this, we do not successfully change our attitude toward the patient . . . [p. 130].

Finally, four months later, on the last day he wrote in his Diary, Ferenczi noted that, when he attempted to switch from mutual back to unilateral analysis with patients, the “emotionality disappeared” and the analysis became “insipid” and the relationship “distant.” He concluded that “once mutuality has been attempted, one-sided analysis then is no longer possible—not productive.” Exploring to the very end he asked, “Must every case be mutual—and to what extent?” (p. 213). Ferenczi, who died in 1933, never settled within himself the question of exactly what the extent and nature of his openness and counteranaly-

sis needed to be. But he never gave the question up. It compelled him. It was central to his work.

“Must every case be mutual?” Ferenczi asked in 1932. Can a case incorporate elements of mutual analysis? In what respect is psychoanalysis inevitably a mutual process? are questions that I have been exploring in this book. I want to explore what Ferenczi thought that he was doing in his attempts at mutual analysis, what he learned from these experiments, and what we may learn from them regarding our own affective involvement and openness with patients. Let us look at the “temporarily abandoned workings” of Ferenczi’s clinical thought and practice to see if we might find “new veins of gold.”

One of the most important discoveries Ferenczi made about the emotional openness of the analyst was that it allowed patients to come to a sense of conviction about the reality of repressed childhood traumas. As Ferenczi moved from a more reserved to a more open stance, he became convinced that it was only through the very natural emotional response of the analyst that patients could come to believe that the traumas that they were remembering were in fact real. The response the patients had originally received from their parents was being repeated in the largely silent, cool, reserved response of the analyst. As Ferenczi (1932) stated, “In most cases of infantile trauma the parents’ cure is repression—it’s nothing at all; ‘nothing has happened’; ‘don’t think about it’ . . . The trauma is hidden in a deadly silence. First references are ignored or rejected . . . and the child cannot maintain it’s judgement” (p. 25).

Ferenczi’s beliefs about the importance of the analyst’s emotional responsiveness to the patient’s reliving of childhood trauma are beautifully stated in a Diary entry of January 31, 1932:

Patients cannot believe that an event really took place, or cannot fully believe it, if the analyst, as the sole witness of the events, persists in his cool, unemotional, and, as patients are fond of stating, purely intellectual attitude, while the events are of a kind that must evoke, in anyone present, emotions of revulsion, anxiety, terror, vengeance, grief and the urge to render immediate help; to remove or destroy the cause or the person responsible; and since it is usually a child, an injured child, who is involved (but even leaving that aside), feelings of wanting to comfort it with love, etc., etc. [p. 24].

Moreover, it is the unguarded communication of the deepest empathy inherent in the analyst’s responses that Ferenczi sees to be affectively engaging and healing. Ferenczi suggests that the depth of his empathy results from his experience of the patient’s suffering coming together with the experience of his own suffering. In his experiments with mutual analysis, Ferenczi permitted this commingling of experi-
ences to occur in a highly radical way. For example, in one session, RN's counteranalysis of Ferenczi led him to explore with her an episode from his own infancy. For the first time, he felt emotion about it and had the feeling that it had been a real experience. This insight, in turn, led RN to gain deeper insight into the reality of events in her own life that previously she had grasped only on an intellectual level.

The radical nature of mutual analysis was seen by Ferenczi (1992) to remove fear of the analyst, which removal Ferenczi thought was essential for the lifting of an infantile amnesia. He wrote:

Certain phases of mutual analysis give the impression of two equally terrified children who compare their experiences, and because of their common fate, understand each other completely and instinctively try to comfort each other. Awareness of the shared fate allows the partner to appear as completely harmless, therefore as someone whom one can trust with confidence [p. 56].

Ferenczi identified the freedom from fear of the analyst as "the psychological basis for mutuality in analysis" as it was on this that resolution of the infantile amnesia depended (p. 57). More generally, mutual analysis was found to be effective in loosening repression. With mutual analysis, material that had been censored was disclosed. Feelings and impulses that had been unconscious emerged into consciousness. It was Ferenczi's opinion that the destruction of illusion about the analyst that occurred through mutual analysis made this possible (p. 14).

Ferenczi began to recognize the inevitability of the analyst's participation in the patient's transference. He was the first analyst to consider that the patient's resistance needed to be understood as a function of the analyst's countertransference. He began thinking in terms of what I have been calling mutual participation and mutual enactment. Consider Ferenczi's profound observations regarding patients whom we would today refer to, using Shengold's (1989) term, as "soul murdered."

I have finally come to realize that it is an unavoidable task of the analyst: although he may behave as he will, he may take kindness and relaxation as far as he possibly can, the time will come when he will have to repeat with his own hands the act of murder previously perpetrated against the patient [Ferenczi, 1932, p. 52].

Ferenczi is here proposing a model of the analytic process that is far beyond the simplistic notion that the analyst needs to be a "good object" or better parent to the patient. Here, Ferenczi acknowledges that it is inevitable that the analyst will "repeat with his own hands," will actively participate in recreating the trauma. The analyst has to be a better parent in that, unlike the original, traumatizing parent, the analyst can recognize his or her own participation and can discuss it directly with the patient and, on this basis, change his or her participation. It is in this recognition of the analyst as a participant, pulled into the patient's transference and then observing and interpreting from the countertransference response, that Ferenczi anticipated and led the way for such notions as participant-observation, projective identification, and the usefulness of countertransference.

Ferenczi went even further; not only did he anticipate our contemporary views, but we may still have to catch up with his insights. Not only did he recognize that the analyst is pulled in as a participant in the reenactment of the trauma, that the analyst himself must become the patient's abuser, but Ferenczi also realized that the patient observes this and reacts to it. It is not just that the patient misperceives the analyst as being the abuser in a "transference distortion," but that the patient gets the analyst actually to play that role; the transference is "actualized," in contemporary terms (Sandler, 1976), and the patient then observes the analyst's participation. Unlike some theoreticians who are tempted to use the notion of enactment or induced countertransference as a way of shifting responsibility from the analyst to the patient, Ferenczi insisted that the analyst's own character traits inevitably play a part in the transference and countertransference. Thus, for Ferenczi, transference and countertransference involve mutual participation. Furthermore, the patient can observe the analyst's countertransference responses and character traits and, in turn, react to them. Ferenczi was the first to point out the ways in which the patient becomes the "interpreter" of the analyst's countertransference experience (Hoffman, 1983; Aron, 1991a).

Ferenczi (1931) saw that the patient's transference is not a distortion to be corrected by the analyst. Rather the patient's observations of and reactions to the analyst as a person are to be taken seriously:

It is advantageous to consider for a time every one, even the most improbable, of the communications as in some way possible, even to accept an obvious delusion... thus by leaving aside the "reality" question, one can feel one's way more completely into the patient's mental life. (Here something should be said about the disadvantages of contrasting "reality" and "unreality." The latter must in any case be taken equally seriously as a psychic reality; hence above all one must become fully absorbed in all that the patient says and feels.) [p. 235]

Finally, for Ferenczi, it is the analyst's emotional honesty, combined with goodwill, that establishes the bedrock of trust that is essential to the analytic relationship. These two qualities enable the patient to accept, perhaps even embrace, the reality of the limited and faulted
analyst and the relationship between the two of them. As Ferenczi (1932) stated toward the end of his life,

[the analyst] is not allowed to deny his guilt; analytic guilt consists of the doctor not being able to offer full maternal care, goodness, self-sacrifice; and consequently he exposes the people under his care, who just barely managed to save themselves before, to the same danger, by not providing adequate help ... there is nevertheless a difference between our honesty and the hypocritical silence of parents. This and our goodwill must be counted in our favor. This is why I do not give up hope and why I count on the return of trust in spite of all disillusionment [1932, pp. 52–53].

In his description of analysts failing their patients and then honestly acknowledging their mistakes and limitations until the patients and their analysts come to mutual forgiveness, Ferenczi provides us with a preview of the contemporary self-psychological idea that relationships progress through sequences of disruption and repair (Lachmann and Beebe, 1992). We saw in the previous chapter how contemporary intersubjectivity theory has extended this idea from the realm of mother–infant research to the psychoanalytic context.

Emotional honesty, accessibility, directness, openness, spontaneity, disclosure of the person of the analyst—these create in the patient heightened naturalness, forthrightness, access to the repressed, recognition of and sensitivity to the other, increased self-esteem, and greater realism about, and hence depth, in relationship. This is Ferenczi’s legacy. The essence of his contribution is that it opens up the person of the analyst as a domain in which important analytic work occurs. The analyst becomes a distinct and real person whom the patient genuinely affects and is affected by.

Ferenczi’s experimentation with “mutual analysis” is an inspiring source of reflection for contemporary psychoanalysis. It is a radical clinical technique accompanied by bold and open thinking that leads us to reexamine the very nature of the analytic relationship. Although in the pages to come, I criticize Ferenczi’s experiments with mutual analysis and argue that it is not viable in its extremes, it nevertheless contains rich and vital elements. The legacy that he left psychoanalysis is valuable independent of the specifics of his technical approach. I believe that Ferenczi’s spirit of empirical experimentation must remain alive. Psychoanalysis is no closer now than it was in Ferenczi’s day to a definitive or final technique. We need to acknowledge, as Ferenczi (1931) did more than 60 years ago, that “analytical technique has never been, nor is it now, something finally settled” (p. 235). At the center of the temporarily abandoned workings of Ferenczi’s mutual analysis lie new veins of gold.

HISTORICAL INVESTIGATION OF ELIZABETH SEVERN (RN)

Having examined Ferenczi’s ideas on mutuality gleaned from his own writings, let us take a closer look at his most important case of mutual analysis, his work with Elizabeth Severn (RN). But this time we will examine the treatment as it revealed not only in Ferenczi’s Diary, but also in the most recent biographical and historical scholarship regarding Severn. The following description is based almost exclusively on Fortune’s (1993a, b, 1994) exciting historical research.

Severn’s (RN) eight-year-long analysis began in 1924 and lasted until shortly before Ferenczi’s death. It coincided with the end of Ferenczi’s experiments with his active technique; proceeded through his period of elasticity of technique, relaxation, and indulgence; and concluded with his experiments with mutual analysis. It was this analytic experience, more than any other, that led to Ferenczi’s recognition of the prevalence and pathogenic significance of childhood sexual abuse, which he simply and directly referred to as rape. Furthermore, it was in this analysis that Ferenczi learned of the reciprocal action of transference and countertransference and of the value and significance of countertransference interpretation. Furthermore, Severn assisted Ferenczi in his experimentation with relaxation and trance states, and she taught Ferenczi about the importance of splitting and dissociative phenomena in persons with severe pathology and in victims of childhood abuse.

From historical research we now know that Severn, born Leota Brown, had been a sickly child, plagued with fears and anxieties. She suffered from an eating disorder, headaches, fatigue, and frequent nervous breakdowns. When she reached adulthood, her symptoms included hallucinations, nightmares, and depression, which often left her suicidal. She repeatedly spent time in mental sanitariums and was treated by numerous therapists. At age 27, she felt the calling to become a healer and changed her name to Elizabeth Severn to begin a new life. While traveling as a door-to-door salesperson she found that people valued her advice, so she set up an office and handed out business cards that read “Elizabeth Severn, Metaphysician.” She referred to herself as a Ph.D., although she had no credentials or formal education, and was elected honorary vice-president of the Alchemical Society in London. In 1914, after a brief stay in London, Severn moved to New York where she spent the next 10 years practicing and writing about psychotherapy. Her therapeutic practice consisted in promoting the power of positive thinking, visualization, telepathic communication, and the “healing touch,” with which she claimed to have cured someone of a brain tumor. By 1924, after many attempts at psychotherapy
for herself, including a period with Otto Rank, Severn, considered a hopeless case, decided to try analysis with the analyst of last resort, Sándor Ferenczi. She moved to Budapest, taking four or five of her own devoted and financially well-off patients with her. Reading Fortune (1993a, b, 1994), one gets a sense of just how disturbed and yet how resourceful and powerful Severn was. She became Ferenczi’s analysand and coanalyst. Freud was to call her “Ferenczi’s evil genius.” (Fortune, 1993a).

At first, Ferenczi was intimidated by and disliked Severn. Looking back some years later, Ferenczi wrote, “Instead of making myself aware of these impressions, I appear to proceed on the principle that as the doctor I must be in a position of superiority in every case” (p. 97). Ferenczi disguised his antipathy for the patient and went out of his way to indulge her. By 1928, Ferenczi who was then experimenting with indulgence and driven by what Freud called his favor sanandi, the rage to cure, was seeing Severn twice daily in her hotel room for a period of four or five hours, plus weekends and at night. She was too sick to get out of bed, except, of course, to see her own patients. Ferenczi even allowed Severn to accompany him and his wife on their vacation to Spain. Later, in 1930, concerned about Severn’s deteriorating state, he waived his fees so that her daughter could afford to come and look after her for a few months. Ferenczi would come to refer to Severn as “the Queen.”

Severn interpreted all of this as a sign that Ferenczi had become her “perfect lover” (Ferenczi, 1932, p. 98). Ferenczi protested that this was “all an intellectual process, and that the genital processes of which we were speaking had nothing to do with my wishes” (p. 98). Ferenczi then pulled back from his involvement with the patient and reduced the number of her sessions. At this point Severn accused Ferenczi of hating her. She insisted that she be allowed to analyze him, so that ultimately her own analysis could progress. Ferenczi resisted this suggestion for over a year but ultimately was forced by the logic of his own views to admit that she was right. He did have resentments against her that needed analysis, and who better than she to help him overcome his resistances?

The mutual analysis was literally a dual analysis. They tried a variety of procedures, including alternate sessions and alternate days of analysis, and, for a while, Ferenczi submitted to being exclusively the analysand. Recent historical research described by Fortune (1994) suggests that in the last year of his life, as Ferenczi’s terminal illness was progressively worsening, Severn’s own analysis stopped and for some time (probably in the late fall of 1932) she analyzed him exclusively. On the basis of letters that Severn wrote to her daughter at the time of the analysis, Fortune (1994) has suggested that Ferenczi probably paid Severn for this analysis. He also suggests that Ferenczi insisted that she keep her analysis of him a secret and that she proclaim herself cured by him. (It should be kept in mind that Ferenczi was dying of pernicious anemia and by the fall of 1932 was quite sick and was in and out of sanatoriums for cures.) The analysis finally ended in February 1933, when Severn left Budapest for Paris. At that time her daughter wrote Ferenczi a letter of protest because she found her mother in a state of mental and physical collapse. Ferenczi was too ill to reply to the letter, and he died in May 1933. By June 1933, Severn resumed her own practice of therapy in London and, soon after published her third book on psychotherapy (Severn, 1933). The book makes little mention of Ferenczi or mutual analysis. Years later, Severn’s daughter acknowledged that she had no doubt that Ferenczi’s analysis of her mother had “ultimately saved my mother’s life” (cited in Fortune, 1994, p. 222).

**CRITIQUE**

I have attempted to elucidate in some detail the many rich contributions that emerged from Ferenczi’s clinical experiments with mutuality and self-disclosure. His work has been continually inspiring as a model of openness and directness, for dedication to patients’ welfare, for continual self-reflection on the nature of analysts’ participation with patients, for taking patients seriously, and for not blaming patients for treatment failures. We can continue to learn a great deal from Ferenczi’s efforts. Nevertheless, we also need to face straightforwardly the limitations and excesses of his clinical approach. I believe that the distinctions that I have been making in this book between mutuality and symmetry are helpful in our reexamination of Ferenczi’s project.

In my view, Ferenczi mistook symmetry for mutuality and, therefore, in his clinical experiments abandoned the essential asymmetry required for psychoanalysis. Ferenczi was aware that he was enacting a masochistic submission to his patient’s demands, but in his attempt to avoid being the bad object, to avoid repeating the patient’s trauma, he was unable to find a way both to enter the patient’s system and to interpret his way out of it. To be a part of the system and yet remain out of it requires both mutuality and asymmetry. Using the terms mutuality and symmetry in the way that I have in this book, I would describe what Ferenczi and Severn did together as an experiment in “symmetrical analysis” rather than in “mutual analysis,” in that the roles and functions, and ultimately even the professional responsibility and financial remuneration became blurred, if not completely reversed.
Ferenczi repeatedly claimed that his own analysis was to serve as a resource for his patient's analysis. But for how long could Severn analyze Ferenczi unilaterally, with Ferenczi continuing to believe sincerely that this was ultimately for her good more than for his?

Part of the difficulty for Ferenczi, we see in retrospect, was that inasmuch as he decided to enter into a mutual analysis he took his obligation to free associate seriously, and, understanding this to be the fundamental rule of analysis, he did not leave himself the right as the "analyst" to withhold anything from his patient. This is one way in which the necessary asymmetry broke down between him and Severn. Under these conditions, Ferenczi could not maintain the distance necessary to preserve analytic space between himself and his patient. Furthermore, I would judge that Ferenczi and Severn did not actually engage in a mutual analysis, but rather that they engaged intermittently in two separate, parallel, unilateral analyses. He interpreted her transferences and she interpreted his, but Ferenczi did not consolidate his faint recognition that his transference and hers mutually constituted each other. Analyzing his transference to her and separately analyzing her transference to him, Ferenczi and Severn conducted two independent but overlapping analyses. Mutual analysis would entail their joint recognition that both of their transferences were mutually constituted, and each could be understood only in the context of the other. In addition to his character disturbances, his idealization of "truth," his exorbitant need for love, his longing for further analysis, his isolation from Freud (his friend, hero, and analyst), and the effect of his illness in the last year of his life, Ferenczi just did not yet have the conceptual tools necessary to understand the interweaving of their two transferences.

Ferenczi became overly identified with his traumatized patients and in his state of identification he sought to provide them with the love and reparative experience that he wished for himself. Ferenczi described his mother as "harsh" and unable to supply him with the nurturance he needed (letter from Ferenczi to Freud, 13 October 1912, quoted in Grubich-Simitis, 1986). He identified with his patients' sense of entitlement and masochistically submitted to their demands. In his brief "analysis" with Freud (seven weeks of analysis spread out over a few years) it could hardly be expected that Ferenczi could have resolved these problems. With Ferenczi blurring the boundaries between his own traumatization and that of his patients, it is not surprising that he would develop a technique of mutual analysis in which the very functions of patient and analyst would become blurred. In the reversal of roles in which Ferenczi became the patient and the patient-became the analyst, Ferenczi masochistically submitted to patients' sadistic reenactments of their own childhood abuse. Ferenczi's extraordinary efforts to repair his patients through love was an effort to provide the love that he himself wished for, as well as an attempt, through reaction formation, to disguise his resentment for not having received enough love.

Once again, I believe that, in addition to his personal problems, Ferenczi just did not have the conceptual understanding of the analyst's participation fully worked out. He often wrote as if it were just the analyst's love and empathy that was curative. This is, I believe, only a partial truth. At times, as I have indicated, Ferenczi recognized that the analyst had to be available to the patient to participate in a much fuller way; for example, the analyst had to feel pulled into repeating the patient's childhood trauma. So, certainly, at those moments when the analyst had to enact the role of the "bad parent" the analyst was not being loving and empathic in any simple way (of course, one could say that at those moments the analyst is empathizing with the patient's bad internal object). But Ferenczi resisted the full recognition that he had to allow himself to be the patient's "bad" object, not just the "good," "empathic," loving one. It was in getting caught up in the compulsion to be the "good" object that Ferenczi lost the ability to see the ways in which he, in fact, was failing his patients.

Clearly Ferenczi had a number of characterological difficulties that led him to his technical experiments. He was known for his extreme zeal and particularly for his therapeutic enthusiasm, the *furore sanandi*, that swept him away in one passion after another. He was often described as childlike in his wild enthusiasms and his capacity to let himself go. This trait led him temporarily to go to extremes and to neglect the balanced view one would expect of a more mature thinker. Nevertheless, Ferenczi's enthusiasm served him well in that he pushed things to their extremes and in so doing discovered more clearly than anyone before the underlying assumptions and limitations of certain psychoanalytic ideas.

In this critical scrutiny of Ferenczi's personality and how his personal difficulties led him to the excesses of mutual analysis, it is important that we recognize that this retrospective attack on a theorist's character is an ad hominem argument of the worst sort! Is there any analyst, from Freud onward, who could stand up to biographical scrutiny and emerge unscathed? If we invalidated theorists' contributions because of their personal foibles, there would not be much left of psychoanalytic theory. Indeed, we might ask why, in every discussion of Ferenczi's technical experiments there needs to be reference to his psychopathology? I cannot emphasize enough the incredible damage that has been done in the history of psychoanalysis by casting aspersions of poor men-
tal health on a theoretical opponent. Elsewhere Frankel and I (Aron and Frankel, 1995) wrote:

In our view, subjective factors can provide the basis for a heightened alertness to various psychological phenomena, leading to discoveries that have broad application. Freud's own personal oedipal struggles are an excellent example of this. A person's contributions should be evaluated on their merits. The presence of subjective factors in the contributor—including psychopathology—does not diminish their value [p. 318].

Thus, while I am very interested in the relationship between analysts' theoretical contributions and their personal background, it is one thing to examine this relationship to gain a better understanding and another thing to use these findings to invalidate theoretical formulations or to discredit clinical innovations.

With this word of caution, we may return to our critique. There are entries in the Clinical Diary indicating that Ferenczi himself may have been the victim of sexual abuse (see, for example, Ferenczi, 1932, p. 61). It is hard to know, however, how much credence we should put in these "memories" of Ferenczi since they emerged in the course of his mutual analysis with Severn. One problem is that Ferenczi and Severn were experimenting together with "trance states" and "relaxation" procedures (Ferenczi had a very rich background and had written a good deal on clinical hypnosis), and they were encouraging each other to remember early childhood events. We now know that working in trance states frequently leads individuals to generate and report more material as memory than they would without the use of these procedures. More importantly, however, hypnotic procedures may lead individuals to be inappropriately confident of the accuracy of their memory reports. We now know that it is prudent to be extremely cautious about the effects of hypnotic procedures on remembering (McConkey, 1992). Furthermore, in the context of Ferenczi's and Severn's joint theoretical interests in trauma, the likelihood is enormous that mutual suggestion effects would come into play. I must conclude that any inferences regarding childhood abuse that are based solely on the mutual analysis as reported in the Clinical Diary should not be relied on as biographically true for either Severn or Ferenczi unless they are substantiated by confirming historical evidence. (In fact, Severn, with Ferenczi's encouragement, did hire an investigator to try to establish the historical accuracy of her traumatic memories.)

Ferenczi evidently believed that he and his patients were uncovering the "truth" about his patients' childhoods. Similarly, as Ferenczi recovered childhood memories of his own, he tended to assume that they were veridical portrayals of his childhood experience. Ferenczi came to the conclusion that one of the most deleterious aspects of trauma was the confusion that is engendered by parents' attempts to deny and cover up abusive incidents. He directly related this parentally evoked confusion to the etiology of splitting and fragmentation of the self. Hence, in more contemporary language, it is the mystification of experience that traumatized the patient and led to the shattering of the self. Like contemporary theorists (such as R. D. Laing and E. Levenson) who attribute an etiological role to the mystification of experience, Ferenczi considered the cure to consist of demystifying experience, finding out what "really" happened, uncovering the "truth." Here, however, Ferenczi fell into the trap of polarizing the distinctions between reality and fantasy, truth and mystification, and therefore he maintained a simplified and idealized notion of the truth. As a result, he seems at times to have accepted his patient's (as well as his own) recovered memories of abuse as veridical, literally true; while at other moments he seemed to recognize that these truths were "valid" only perspective, that is, that they expressed the truth of the patient's experience. The question of the veracity of recovered traumatic memories in psychoanalysis continues to be highly controversial. (For a fuller discussion of this issue, see Harris, 1996; Davies, 1996; and Crews, 1996). While most analysts agree that whether traumatic abuse really occurred or was fantasized to have occurred does indeed matter, knowing whether a memory is of a real or fantastical event is highly problematic, and the belief on the part of most clinicians that this difference between fantasy and reality is significant is a serious challenge to those (generally academics, not clinicians) who advocate radical constructivism.

Wolstein (1991) has persuasively argued that the case of RN belongs to the line of historically significant cases for psychoanalytic discoveries that leads from Anna O to Dora to RN. Ferenczi was the controversial, even vilified master during the 1920s and early 1930s of fresh experiment and radical innovation, the likes of which were not seen undertaken with such clinical freedom and far-reaching therapeutic influence since Breuer and Freud wrote up their landmark findings in 1895... That is, from the first study of hypnoid states in Breuer's case of Anna O (1880-1882), to the first awareness of transference in Freud's case of Dora (1900/1905), to the first exploration of countertransference in Ferenczi's case of RN [pp. 168-169].

Now that we have seen how Ferenczi conducted mutual analysis with his patients, it should not be surprising to learn that he also wished to engage in a mutual analysis with his analyst, and indeed he did attempt this. Ferenczi was the only one of Freud's disciples to suggest seriously to the master, who was also his analyst, that he (Ferenczi)
would travel to Vienna in order to analyze him (Freud); Freud appreciatively declined Ferenczi’s offer (see Jones, 1957, p. 120). In attempting to analyze Freud’s countertransferenceal and characterological limitations, Ferenczi was anticipating the role that he would come to outline for the patient, that of therapist to the analyst, given that the analyst can tolerate and encourage this function in the patient.

Listen to the plea as well as the concern in a letter in which Ferenczi offers to analyze Freud. Remember that, by this time, they had been best friends and colleagues for 18 years:

Perhaps this is the occasion on which I can say to you that I actually find it to be tragic that you, who gave psychoanalysis to the world, [find it] so difficult—indeed are not in a position—to entrust yourself to someone. If your heart complaints continue and if medications and diet don’t help, I will come to you for several months and will place myself at your disposal as analyst—naturally; if you don’t throw me out [letter from Ferenczi to Freud, February 26, 1926, quoted by Hoffer, 1994, p. 201].

In response to Freud’s warm, gracious, and moving decline, Ferenczi persists, confronting Freud, the master himself, with his resistance to analysis. Ferenczi writes on March 1, 1926,

Naturally neither can nor should [one] be pressured into analysis, but please keep in your [mind’s] eye that as soon as your disinclination (should I say resistance?) is halfway overcome, I can immediately come to Vienna. . . . I thought of a stay of a few months [p. 202].

As Hoffer points out, Ferenczi’s offer to analyze Freud should be seen, and indeed was seen by Freud, as the offer of a loving gift. Throughout their relationship, from beginning to end, Ferenczi’s longing for mutuality included both the desire for greater intimacy between himself and Freud as peers and the continued mutual need to be cared for by Freud and to care for him in turn. The theme of mutuality runs through Ferenczi’s life, whether as patient, as analyst or as friend. He knew that his idealization of mutual honesty had neurotic origins, but as to that he wrote, “There is certainly much that is infantile in my yearning for honesty—but it certainly also has a healthy core—Not everything that is infantile should be abhorred” (p. 224). (For a more detailed study of Ferenczi’s lifelong yearning for mutuality, see Aron, 1995b.)

We have seen that mutuality does not imply equality and needs to be differentiated from symmetry. And we have seen how Ferenczi’s attempts at mutuality became confused with symmetry and ultimately broke down. The question to be considered is, can there be some increase in mutual disclosure without necessarily compromising the necessary differences between patient and analyst? This is a modification and extension of Ferenczi’s question, “Must every case be mutual—and to what extent?” Let us first turn to the contributions of Ferenczi’s friend, colleague, and collaborator, Otto Rank, and see the ways in which his work converges with and yet departs from and complements Ferenczi’s innovations.

**CHAPTER SIX**

**OTTO RANK AND THE BIRTH OF INDIVIDUALITY**

Otto Rank and Sándor Ferenczi not only were collaborators on an important treatise on psychoanalytic technique, they also shared a common fate; to different degrees, both men were ostracized and their writings suppressed or dismissed. Aspects of Ferenczi’s work were sequestered from psychoanalytic study by Jones, who kept Ferenczi’s final paper from being translated into English for some 16 years; for a variety of reasons (see Aron and Harris, 1993), Ferenczi’s Clinical Diary was not published for over half a century. Similarly, nothing that Rank wrote after his break with Freud was read or cited by classical analysts, and much of it was never even translated into English. None of Rank’s work is ever assigned as reading in classical institutes, while Ferenczi’s work has only recently begun to receive renewed attention. Jones (1957) forever linked the two men when he wrote that

Rank and Ferenczi, were not able to hold out to the end. Rank in a dramatic fashion . . . and Ferenczi more gradually toward the end of his life, developed psychotic manifestations that revealed themselves in, among other ways, a turning away from Freud and his doctrines. The seeds of a destructive psychosis, invisible for so long, at last perinnated [p. 45].

This was only one of the more dramatic ways in which Ferenczi and Rank were marginalized by the analytic establishment. Jones’s comment not only maligns them as people, but leads to a dismissal of their contributions as manifestations of their psychoses.

Whereas Ferenczi was able to stay within the psychoanalytic movement (although only because his final experiments were not made public), Rank lived from 1926 to 1939 in exile, excommunicated from the psychoanalytic world. Rank belatedly found some historical luck, however, in a way that Ferenczi did not. Specifically, Rank is the subject of an appreciative intellectual biography by E. James Lieberman (1985); there is as yet no comprehensive biography of Ferenczi.
Lieberman’s biography, together with the extensive rediscovery of Rank by Esther Menaker (1982), has led to the recent reemergence of interest in his work.

Rank, like Ferenczi, was a pupil and close associate of Freud. Rank’s role within Freud’s inner circle, was as Freud’s adopted son. Lieberman (1985) reports that Rank, alone among the close associates, regularly edited and contributed to Freud’s writings, and Freud even went so far as to include chapters written by Rank in several editions of *The Interpretation of Dreams*. From 1912 to 1914, Rank was the editor of the first two psychoanalytic journals: *Imago* and *Internationale Zeitschrift für Psychoanalyse*. From 1919 to 1924 he directed Freud’s psychoanalytic publishing house, *Der Internationale Psychoanalytische Verlag*. Rank’s collaboration with Ferenczi occurred around 1923, the same year that he wrote *The Trauma of Birth* (Rank, 1929). It and *The Development of Psychoanalysis* (Ferenczi and Rank, 1924) initiated a brief transitional period before Rank was tragically to part company with Freud and Ferenczi. *(The break among these men was tragic for all of them.)*

*The Development of Psychoanalysis* is best remembered for the stress that Ferenczi and Rank placed on the mutative primacy of experience in the here-and-now of the transference. At the time of its writing, Freud’s emphasis on intellectual insight as the agent of change. This focus was even more true of the Berlin school, as the approach of Karl Abraham and Hanns Sachs was known, which was devoted to theory and intellectual understanding in the attention that it did pay to therapeutic considerations. In striking contrast to this concentration on the intellect, Ferenczi and Rank championed the living and reliving of affective experience. Ferenczi and Rank, along with stressing the experiential, also valued the importance of action and repetition over verbal memory. “Thus we finally come to the point of attributing the chief role of analytic technique to repetition instead of to remembering” (Ferenczi and Rank, 1924, p. 4). Their recommendations for the analyst’s active therapeutic interventions were linked to what they believed was the necessity for the patient’s active reliving and reenacting of experience. Ferenczi and Rank did not advocate the elimination of insight, understanding, or memory; rather, they believed that these needed to follow after enactment and experience.

Rank’s (1929) *The Trauma of Birth* was not intended by him as a heresy, but it soon was viewed as one. It is best known for its assertion that the origin of anxiety lies in the act of birth, an idea that Rank attributed to Freud and that Freud, in turn, attributed to Rank. Rank initially thought of the trauma of birth as, quite literally, a physical trauma that left its mark in the form of psychic anxiety. But soon after the book’s publication, Rank made it clear that he was advocating the importance of psychological separation experiences, particularly the child’s initial separation from the mother of infancy. The trauma of birth came to mean the trauma of psychological birth, human separation and individuation. Rank’s early study of separation-individuation certainly stands as an important precursor to much of the relational tradition and especially to the contributions of Mahler, Winnicott, and Kohut. *(This theme is traced by Rudnytsky, 1991 as well as in Menaker, 1982.)*

In shifting his understanding of the origins of anxiety from castration anxiety to the birth trauma, Rank was not only moving the origins of anxiety back in time, from the oedipal to the preoedipal, he was also shifting focus from the father as the important object to the mother. For Freud, the important figure was the patriarchal father who threatened the son with castration anxiety, and the central drama of childhood, the nucleus of neurosis, was the Oedipus complex. Psychoanalysis, until the early 1920s, paid relatively little attention to the relationship to the mother. Rank was not alone in challenging this neglect of the mother. Groddeck (1923) and Ferenczi (1932, 1933) also gave consideration to the mother, but they did not give the mother the centrality in theory that Rank did. Melanie Klein (1932) would soon come to give the preoedipal mother due importance, but she did not cite Rank following his *Trauma of Birth* because he represented her worst nightmare—a heretic who was excommunicated (Grosskurth, 1986).

Rank argued that the central drama of life begins with the vicissitudes of human separation and individuation in relation to the preoedipal mother. Rank’s great discovery, however, was in linking this idea with the analysis of transference. For Rank, the most fundamental transference to the analyst was as the mother from whom one had to separate and establish one’s own individuality. Rank (1929) came to view the psychoanalytic process as an act of psychological birth in which patients create themselves anew with the help of the analyst, who serves as midwife.

The image of the analyst as a (presumably female) midwife is telling, particularly in contrast with Freud’s portrayal of the analyst as a (presumably male) surgeon. We might speculate regarding the impact of Rank’s ideas on the male analysts of the 1920s. We know that Freud himself acknowledged that he was uncomfortable being placed in the role of mother in his patient’s transferences. He wrote to the poet HD (1933), “I do not like to be the mother in the transference, it always surprises and shocks me a little. I feel so very masculine” (pp. 146-147). Undoubtedly, other analysts had reactions similar to Freud’s; they may have been more comfortable viewing themselves as distant and
detached male authorities than as women, who have to participate in the birth process. In any event, it was just these ideas that would be at the heart of the dispute that led to Rank’s rejection. Jones (cited in Lieberman, 1985, p. 223) reported that when James and Edward Glover criticized Rank’s birth trauma theory, it was precisely these two points that they attacked, the rejection of the centrality of the father and the displacement of primary importance away from the Oedipus complex.

As Rank took leave of Freud and the psychoanalytic establishment, Freud interpreted to him that his theory was a way for him to defend against his own oedipal conflicts, particularly in regard to his wish to disregard the father. Rank countered that the personal experiences that lead to insights and theoretical formulations are not relevant to evaluating their worth. In addition, Rank countered with an interpretation of his own. From his point of view, Freud’s interpretation of the Oedipus myth ignores the fact that the father Laius set out to kill his son because of his own fears of being displaced by him. Now, he insinuated, Freud, the patriarchal father, was afraid that he would be displaced by the elevation of the mother in Rank’s theory and by his adopted son, Rank, in intellectual life. From Rank’s perspective, Freud, like Laius, would renounce his son rather than face his own inevitable mortality.

As Rank developed his ideas in the years following his separation and individuation from Freud (his own psychological birth), he elaborated a unique vision of psychological development and constructed what amounts to a “psychology of the self.” His focus became the development of personal autonomy and the existential creation of meaning. Individuation begins with the early psychological separation from the mother, proceeds through the development of the will, and culminates in the creative act of generating a unique personality, a distinct self. Rank defined the will as “an autonomous organizing force in the individual which does not represent any particular biological impulse or social drive, but constitutes the creative expression of the total personality and distinguishes one individual from another” (cited in Lieberman, p. 404). For Rank, the will is active rather than reactive; it implicates that force in people which leads them to experience themselves as active agents of their own lives, authors of their own texts, forgers of their own destinies.

Rank (1945) appropriately entitled a chapter in his book Truth and Reality, “The Birth of Individuality.” He explained that will always develops in relation to others. Originally, will develops in opposition to the mother, as one aspect of the child’s separation from her. Will begins as counterwill, and since the expression of will always takes place in relation to and at the expense of the other, the exertion of one’s will inevitably leads to feelings of anxiety and guilt. Neurosis comes about when the person has achieved individuality too much through negative or counterwill and is therefore trapped in conflict between autonomy based on opposition and the wish for love and connection. The most fundamental conflict that we struggle with is between birth, life, separation, and individuality on one side and dependency, merger, loss of self, the symbolic return to the womb, and death on the other.

Will therapy, as Rank came to call his approach, has to do not with intellectual understanding and cognitive insight, but with the affirmation of the patient’s will in relation to the therapist. Calling for an active, flexible, and creative approach on the part of the therapist, Rank suggests that the therapist accept the patient as a person and encourage his or her psychological birth through acts of will. The restoration of confidence that is brought about through the therapeutic interaction liberates the patient’s will and ushers in the birth of individuality. We will see in the next section of this chapter how this therapeutic perspective leads to a significant transformation in the meaning and clinical approach to resistance.

Clearly, Rank’s approach emphasizes the centrality of relationship. More specifically, he anticipated many of the distinguishing marks of contemporary relational theories. Indeed, in 1929 Rank defined psychology as a “science of relations and interrelations” (Lieberman, 1985, p. 283). He speaks of the early relationship to the preoedipal mother and how this early relationship is reenacted in the transference. He focused clinically on the here-and-now and on the experiential reality of the immediate therapeutic interaction. He advocated an active and flexible therapeutic approach and he took an affirmative approach to resistance. His overall approach, however, represents a psychology of the self in that he (much like Mahler, Pine, and Bergman, 1975) sees the direction of growth from merger toward separation and individuation as culminating in the independence of self, rather than as movement from nonattachment to attachment (more in keeping with such thinkers as Bowlby, 1988, and Ainsworth, 1982). Of course, all these theorists would recognize that attachment needs to be balanced with exploratory behavior, connection with separation. Nevertheless, the direction of their approaches remains important. Rank privileges the move away from the other, toward autonomous self-functioning. This is true notwithstanding that he also came to see certain acts of merger as steps in the direction of creativity. The thrust of his theory is in the direction of autonomy, individuality, and the self.
RELATIONAL PERSPECTIVES ON RESISTANCE

Resistance is one example of the ways in which Ferenczi's and Rank's contributions can be seen to anticipate contemporary relational developments in psychoanalysis. Ferenczi's and Rank's ideas complement each other, and taken together they constitute the heart of contemporary relational thinking. Contemporary analysts have approached the concept of resistance quite differently from the way in which it has been treated by classical analysts. Classical analysis views resistance as opposition to the analytic work. In early Freudian thinking, resistance was viewed as opposition to remembering traumatic events. Later, its connotation shifted to opposition to the uncovering of repressed infantile wishes. Greenon (1967) writes, “Resistance means opposition ... operating against the progress of the analysis, the analyst, and the analyst's procedures and processes” (pp. 59-60). Sandler, Dare, and Holder (1973), in their review of the classical approach to the concept of resistance, describe resistance as concerned “with elements and forces in the patient which oppose the treatment process” (p. 71, italics added). I suggest that relational revisions have occurred along two related lines corresponding to the two phrases that I highlighted in the foregoing definition of resistance. First, there has been an effort to reconsider the location of resistances, by rethinking whether they are best thought of as “in the patient.” Second, there has been an effort to remove the pejorative connotations of the word resistance by questioning whether these behaviors really “oppose the treatment process.”

British object relations theorists have approached resistance along more affirmative lines than did classical theorists. Fairbairn (1952) conceptualized resistance as based on the fear of retraumatization. He conceptualized the antibibalinal ego as a source of resistance to the emergence of dependency needs on the part of the needy libidinal ego, and he spoke to patients' fears of relinquishing their ties to internal bad objects. Guntrip (1969), following Fairbairn (1952), viewed resistance as due to fears of feeling or appearing weak or inadequate and therefore experiencing shame and humiliation. Patients were therefore motivated to keep their self-experience of being weak and needy out of awareness and to keep their therapists at a safe distance. This object relations approach to resistance was an improvement on the classical approach in giving priority to the patient's needs for safety. It therefore may be seen as representing an affirmative approach to resistance. Unfortunately, however, this aspect of the theory alone continues to lend itself to the analyst's interpreting resistance in a critical manner, for the analyst may imply that patients should not be so afraid of taking risks or exposing their vulnerabilities. The analyst may interpret the experience of lack of safety as an intrapsychic one and not connect it to his or her own behavior in the present clinical encounter. In other words, the patient’s sense that the analyst is dangerous may be interpreted as a transference distortion rather than accepted as a plausible view of the analyst. In addition, however, to viewing resistance more affirmatively, some British Independent analysts have also shifted to a view of the analytic process in which both patient and analyst are locked into mutually constituted resistances (Kohut, 1986).

Kohut (1971, 1977), more than any other psychoanalytic theorist, led the way in revolutionizing our understanding of resistance. Self psychology views resistance as the self's attempt to protect itself not against drive derivatives, but against the repetition of traumatic experience. People live with the dread of being retraumatized by bad objects. From this point of view, resistances are healthy and necessary functions of the self. Self psychology has taken the affirmative approach even further by suggesting that patients' resistances must be taken to mean that patients experience their analyses as dangerous; and rather than blame patients for not feeling safe, analysts must consider what they are doing that continues to keep the patients from feeling secure. Analysts must consider that what seems like resistance in patients is actually a response to an interpersonal event, a failure of empathy on the part of the analyst.

Schafer (1983, 1992) is a leader in the reconceptualization of resistance within post-ego psychological psychoanalysis. First, Schafer (1983) has encouraged analysts to remove the pejorative connotations of the concept resistance by taking “an affirmative theoretical and clinical approach to resisting. This affirmative approach focuses largely on what resisting is for rather than simply what it is against” (p. 162). Schafer suggests that the classical tradition encourages an adversarial conception of resistance that leads away from an analytic attitude and potentially represents a significant interference with the analyst's empathy. Rather than view resistance as opposition, Schafer suggests that resistance is the patient's “next significant step in the analytic process” (p. 171). His critique clearly challenges the accepted idea that resistances “oppose the treatment process.”

More recently, Schafer (1992) has gone even further in his critique of the classical approach to resistance. Schafer now makes the more radical suggestion that we eliminate resistance as a central factor in the analytic process, and in its place he suggests that we substitute the analysis of countertransference: “In place of the analysis of resistance, we may install the analysis of countertransference alongside the analysis of transference and defensive operations as one of the three emphases that define a therapy as psychoanalytic” (p. 230). Schafer's point is that much
of what we have traditionally thought of as resistance is behavior on the patient’s part that has elicited negative countertransference. He acknowledges that these ideas about resistance are not completely new or original but, rather, derive from a variety of theoretical frameworks, including that of self psychology. Nevertheless, Schaffer is entitled to much credit for systematically rethinking these ideas.

Let us return now to Ferenczi’s and Rank’s ideas about resistance. As our review of Ferenczi’s clinical contributions would lead us to expect, in his reconceptualization of the psychoanalytic endeavor, Ferenczi challenged the classical approach to resistance. Rather then view resistance as due to defense against instinctual drives, Ferenczi began to view it as an expression of the patient’s developmental needs and as a specific response to the analyst’s countertransference.

Ferenczi (1931) attributed occasional failures not to the patients’ unconquerable resistances or impenetrable narcissism or to “incurability” or “unanalyzability” but rather to his own lack of skill (p. 128). One of Ferenczi’s important clinical contributions was his critique of the idea of analyzability and his refusal to blame the patient for a failed treatment. While forthrightly acknowledging his own limitations, he persisted in experimenting with technique in the hope that a new approach might ultimately be of benefit to even the most hopeless of cases.

Ferenczi recognized that resistance not only was determined by internal defenses of the patient but also was provoked by the analyst. Rather than interpret the patient’s resistance, which could amount to blaming the patient, Ferenczi advocated that the analyst listen differently, modify his or her technique, and respond more naturally and lovingly. He recognized the reasonable act of self-protection contained in the patient’s resistance. Ferenczi (1928) suggested that the analyst’s lack of empathy stimulates the patient’s resistance. With these recommendations, Ferenczi anticipated some of Kohut’s (1971, 1977) most salient technical contributions to the understanding and management of resistance, especially in identifying the mutuality inherent in what until then had been seen as resistance in the patient. He began to listen to patients as they interpreted to him what they observed of his own resistances. Ferenczi’s contribution, then, was to reconceptualize resistance as something that existed between the patient and the analyst, in the relationship rather than in the patient’s mind.

Rank (1945) too, in his own way, reformulated the classical notion of resistance. For Rank, the need for self-definition is universal. The striving for individuation finds expression in the manifestations of the individual will, which always begins as counterwill, opposition to the will of the other, such as the familiar negativism of the small child. The ability to will depends on obtaining the affirmation of the other. One thinks here of Rene Spitz’s (1959) idea that, for the child, learning to say no is an important developmental organizer of the psyche. Like Rank, Spitz linked this developmental achievement with the early development of object relations and with the “emergence of the self and the beginnings of social relations on the human level” (p. 97). It is critical that parents not squelch their children’s early efforts at individuation through the exercise of their will. Rather, parents need to understand that their children’s negativity and oppositionalism represent fledgling efforts to separate and exercise autonomy and that these efforts need to be met with parental affirmation (which is not to say that parents need to submit to the whims of their children). Rank (1945) implies that this parent-child situation is analogous to the therapy situation where what looks like negativity and opposition (the resistance) needs to be seen as the patient’s efforts to exercise autonomy and self-definition, efforts that need to be met with recognition and affirmation by the therapist (although, once again, this does not mean that the therapist needs to comply with the patient’s will).

Bromberg (1995) has elegantly written about resistance and human relatedness in a way that is strikingly reminiscent of Rank’s thinking:

I would argue that the human personality, in order to grow, needs to encounter another personality as a separate center of subjective reality, so that its own subjectivity can oppose, be opposed, confirm, and be confirmed in an intersubjective context. "Resistance-as-obstacle" functions inherently as a necessary guardian of self-continuity during this process and, in that sense, an obstacle, as opposition, is an intrinsic aspect of the growth dialectic that makes clinical psychoanalysis possible (p. 176).

Together, Ferenczi and Rank have provided the conceptual tools necessary to rethink resistance. From Ferenczi we take the idea that resistances are to be seen as existing in the communion between patient and analyst, that they are mutually constituted as part of the two-person relational system. Resistances in the patient may well arise in reaction to the analyst’s countertransference instead of vice versa. From Rank we learn that resistances are to be viewed affirmatively as important steps in the patient’s development of will, which, if these resistances are met by the therapist’s affirmative response, will lead to individuation, autonomy, and agency. Both Ferenczi and Rank saw resistance in the context of the relational system. From Ferenczi, we take a focus on mutuality; from Rank, a focus on autonomy. Together they anticipated the dialectical approach that constitutes contemporary relational thinking, balancing agency and communion, one-person and two-person psychologies.