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COMMENTS ON "CONFUSION OF TONGUES"

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FERENCZI'S PAPER, "CONFUSION OF TONGUES

Between adults and the child: The language of tenderness and passion, " was published in 1933 (Ferenczi, 1949). In it he reveals his work with analytic patients whom we might characterize today as examples of the "negative therapeutic reaction" (Lane, 1985). He serves as an object lesson of an analyst both good and creative. He used transference to elucidate countertransference, which he then used to validate and to analyze the transference. In this manner he transformed the analytic experience, and raised issues which we are discovering "anew" year in and year out. These topics include the analytic situation and "climate, " the experience of transference and its genetic roots, and aspects of the nature and impact of seduction and trauma in childhood.

I will review and comment upon this classic, and will link Ferenczi's insights with those of others who followed, and who, by and large, gave him precious little credit for antedating their discoveries. I will offer examples of work with patients who had been traumatized in childhood to illustrate aspects of engaging people prone to negative therapeutic reactions. These clinical notes will validate Ferenczi's comments on the relationship between childhood trauma and the development of deep personality splitting, even fragmentation. Ferenczi begins by noting a mistake on his part: a "regression in technique … to which (he) was forced by certain bad or incomplete results." He had been wrestling with modifying psychoanalytic technique (and theory) to improve unsatisfactory therapeutic results. He was concerned with that group of patients who while on the couch almost hallucinatorily reproduced past traumas, which seemed to justify the hope that the forced abreaction of repressed affect would enable the conscious mind to deal with such feelings without the development of new symptoms. The shift in theory had to do with what he came to regard as a premature and facile explanation of the vulnerability to neurosis in terms of "disposition" and "constitution." The "Confusion of tongues" paper redressed this error in theory: for Ferenczi's re-evaluation led him to place greater credence in the role of childhood experience, especially the facts of abuse and seduction, in creating neurotic states, especially those transference neuroses which persisted despite seemingly correct analyses.

Ferenczi's worry led him to admit the failure both of classical analysis and of his active therapy. He came to listen in a different way to his patients' attacks, when they called him insensitive, heartless, or shouted at his letting them flounder helplessly. Giving free rein to self-criticism, he sought the truth in their reproaches, looking beyond his good intentions. It was noteworthy that such criticism was rare, even from those patients who benefitted least from analysis and who were most traumatized in (by?) it! Most of these patients were strikingly compliant and accepting of the analyst's interpretations. Even when Ferenczi discovered that anger underlay their passivity these submissive souls could not be roused to anger by his exploration of this dynamic, nor by his encouragement not to spare him their disapproval.

He gradually came to the conclusion that patients were remarkably sensitive to the analyst's personality and his unconscious preferences. Rather than contradicting him or accusing him of mistakes, they identified themselves with the analyst. Their criticism did not become conscious, except in dissociated states, for instance, hysterical excitement, or rarely when the analyst specifically encouraged such criticism.

It would be an impossible situation were our patients to be better analyzed than we, yet unable to express

their superiority or judgments for fear of "occasioning displeasure" in us. Our own analyses are crucial in this regard: not to enable to know everything about ourselves, but to open ourselves to the possibilities of unknown unwelcome truths.

Analysts must face their resistances to discovering unpleasant character traits and behavior.

To this point, Ferenczi has been revolutionary. He shifted the focus from transference as representing the spontaneous replay of infantile and childhood conflict to a focus which sees transference as commentary upon the experienced person of the analyst. Further, he identifies the interplay of the dynamic unconscious of analyst and patient, regards its communicative possibilities as valid if not essential to understanding the persistence of the transference neurosis, and asserts that self-analysis and openmindedness is necessary if the analyst is to catch onto his countertransference, in turn a precondition for examining his relationship with his patient.

Ferenczi is dealing with the "secret loving and secret hating" (Klauber, 1981) of patient and analyst. He is pathfinder to the more extensive mapping of the territory by Gill and Hoffman (Gill, 1982), (Gill and Hoffman, 1982) where transference phenomena reflect upon and potentially clarify countertransference phenomena, and vice versa.

Ferenczi forges on. Not content to process the experience in self-analysis, he transforms the analytic setting and makes a clean breast of his inner secrets. He was unable to see any other way out than making his own disturbance fully conscious and discussing it with his patients. (I suggest that the discussion with patients catalyzes fuller awareness in consciousness.) From the candor and incisiveness of his writing, we know Ferenczi fully unmasked his "professional hypocrisy": the difficulty tolerating some features of the patient and the unpleasant disturbances of our affairs in the analytic session. He reports: "Such renunciation of the 'professional hypocrisy' … led to a marked easing" of the patient's condition. Hysterical attacks became milder; past tragedies were remembered in thought, not disorganization.

The admission of mistake had changed the analytic situation from one whose authoritarian coldness repeated the original trauma of the parents' concealed dislike of the child, which in childhood had led to the illness. For most patients, this admission served as a "corrective emotional experience" (Alexander, 1958). The free and honest communication had created in the patient a confidence in the analyst. " It is this confidence that establishes the contrast between the present and the unbearable traumatogenic past, the contrast which is absolutely necessary for the patient in order to enable him to re-experience the past no longer as hallucinatory reproduction but as an objective memory."

Ferenczi recognized that some patients would be unmoved (from a competitive dynamic), as he cited "one highly intelligent patient (who) became justifiably indignant, saying, "It would have been much better is you could have avoided blunders altogether. Your vanity, doctor, would like to make profit even out of your errors."

Ferenczi's confession recalls Little's (1951) suggestion for using countertransference reactions with our most disturbed patients: that the analyst accept, admit, and—when possible—explain his mistakes. Patients' deep paranoid anxieties can thus be relieved through experiencing the analyst as a human, that is, fallible, being. Winnicott (1949) went even further in his paper "Hate in the countertransference." In this direct exposition, he indicated that analysts could and should hate on occasion: when the patient was asking to be hated and needed just that "objective" feedback. For, if the patient could not reach the justified hate he sought, neither would he be able to reach objective and felt love. These analysts have expanded psychoanalysis from a system of interpretation of and to the patient, to include interpretation of the analyst via the patient's transference, to modify the role and presence of the analyst. They accept the analyst's full interpersonal and intersubjective participation in shared exploration and dialogue, accept the responsibility to be influenced by and to change in the service of the patient and the analysis, and actively to try to supply missing emotional experience and personal meaning. As Semrad, was later to put it, the therapist's first task was to "investigate, investigate, investigate", to seek what was missing in the patient's life and then to try to supply it in the therapeutic relationship, in feeling, thought, fantasy, perspective. Then, he advised, continue to investigate the impact, or apparent lack of impact, upon the patient. Semrad's explorations in the uses of empathy and self should be better known outside the Boston area. (See Rako and Mazer,

1980); (Semrad and Zaslow, 1964) ; (Havens', 1986, studies on the uses of empathy and countertransference which were nourished, in part, by Semrad's work) ; (and the volume edited by Epstein and Feiner, 1979, Countertransference: The Therapist's Contribution to the Therapeutic Situation, which discusses these issues more fully.)

A few words on mistakes. Ferenczi did not merely apologize away responsibilities and gloss issues as do others by labelling them and burying them (Tuchman, 1987). Attention paid to the microscopic ebb and flow of an interview may shed light on the most recondite of transferences; so little mistakes may have big impact, and their discovery may be of major importance in clarifying communication. By the same token, the analyst's willingness to step forward (not submit) to scrutiny implicitly assumes responsibility for his activities and their potential influence upon the patient. Despite articles which call our attention to the anxieties involved in influencing and being influenced (Feiner, 1979), systematic searches for latent influence are still too rarely made in cases when it may be especially important: e.g., with the "difficult" patient, amidst a therapeutic impasse or negative therapeutic reaction, or with the patient mired in an affectless depression or state of sustained embitterment and unhappiness. Once the analyst can conceive of negatively as well as positively influencing the patient, the specifics his interaction may be clarified. At this juncture, a simple apology may be more helpful than the analyst's "explaining" and "making profit" of it. A dramatic presentation of the power of sorrow and apology (in this instance no simple matter) to reach and to move a deeply regressed child was provided by Kubie and Israel (1955). After the admission, then the move beyond the regret to analyze.

Havens (1973) has traced the evolution of psychiatry as a discipline highlighting the interpersonal distance of the doctor-patient relationship. To simplify, psychiatry initially was a profession in which the doctor stood (or sat) at a distance, observing patients' behavior and symptomatology, diagnosing and collating according to scientific objectivity and reification. A more cooperative approach was heralded by Adolf Meyer's careful social history-taking and life-review, which evolved to Sullivan's participant-observation, which permitted not only shared review of the historical reconnaisance, but also of transactions taking place in the consulting room, where doctor and patient were no longer separated by a desk. A closer and more collaborative therapy was attempted by existentialists, who strive sympathetically to share the world-views of their patients and to attune themselves to their affective lives. Synthetic and original minds described and refined therapeutic interplay and intervention (e.g. Fromm-Reichmann, 1961) and formulated the usefulness of corrective emotional experiences (Alexander, 1958).

Ferenczi was not content merely to enjoy a happy therapeutic outcome. He used the progress to analyze the analytic situation itself, in a way that led naturally to Stone's (1961) critique and to Greenson's (1967) thesis The Theory and Technique of Psychoanalysis. Convinced that the hypocritical professionalism and latent antipathy for the patient had veritably reproduced the childhood traumatic situation and state in the office setting, Ferenczi viewed patient's hysterical reenactments as "actual regressions, " in which patients became children indeed. Such regressed child-patients required friendliness from the analyst so as to inspire confidence and provide security. Intellectualized explanations of clarification and interpretation did not suffice. Ferenczi took responsibility for the conduct of the analysis, as Kaiser later was to teach (Fierman, 1965). Analysis was not limited to the passive following of the patient's productions or progress.

Once a more collaborative relationship had been established, Ferenczi's patients provided data about traumatic events and situations in childhood. Their information corroborated Ferenczi's belief in the high frequency of traumatic seduction, violence and rape of children who were to become patients. He came down clearly on the side of that argument which stresses that actual trauma engenders neurosis and character disorder, not necessarily childhood fantasies of seduction or trauma. He outlined three typical traumatic situations of childhood wherein adults passionately bind children to them: incestuous seductions, unbearable punishments and the terrorism of (the parent's) suffering.

Typically, incestuous seductions grow from the soil of adult and child loving each other, "the child nursing the playful fantasy of taking the role of mother to the adult" (typically daughter to father). Whatever the erotic components, the play remains on the level of tenderness, given normal parents. Not so with pathological adults, who "mistake the play of children for the desires of a sexually mature person" and let

themselves be carried away, drugged, intoxicated, or not. The assaulted and betrayed child usually does not react with hatred, disgust, refusal; rather is paralyzed by anxiety. Immature and overwhelmed, the physically and morally helpless child cannot protest. If the child's anxiety mounts, it eventually "compels them to submit themselves like automata to the will of the aggressor, to divine each one of his desires and to gratify these; completely oblivious of themselves they identify themselves with the aggressor."

Reversals and splitting occur. As the aggressor is internalized or introjected, the external attack is denied and the child re-establishes the previous external situation of tenderness, with a new internal dreamlike state, using primary process mechanisms. Further, the child identifies with the unconscious guilt of the aggressor, guilt which has led him to threaten and to coerce the child to secrecy. The child then comes to regard the previously harmless play as "a punishable offense." Ferenczi observes that the other parent is frequently "not intimate enough" for the child to find protection or aid in her. Thus sexuality remains "undeveloped or assumes perverted forms."

Here's an example: I met B, then 25 and single, on a locked ward. She displayed catatonia, suffered perceptual distortions and many psychosomatic symptoms. She had not abused drugs; physical and neurological examinations were normal. She had decompensated when her woman therapist had interpreted her "homosexuality" and then went on vacation. Previously, B worked as a representative of a prosyletizing religious sect, Strident, out of the mainstream, she was often verbally abused, scorned, ridiculed. Polymorphously perverse, she was subject to attacks of panic and obsessional doubting. She showed automatic obedience, having sex with whomever wanted it with her, usually out of sympathy for their alleged needs. Years of therapy had not eased psychic or somatic distress, nor had it led to change in conflict-laden and unsatisfying relationships.

Nonetheless she liked her therapists and felt they had aided self-understanding.

Her parents had been orphaned by the Holocaust. An only child, she was doted on until she was three, when her father was forced to take a job in a foreign country. Mother was embittered and depressed at having to remain in America. Father could call home for a brief time every several weeks. Mother severely rationed B's telephone talk with him. B recalls sitting by for what seemed like hours as mother spoke with him. If she protested, she was threatened or hit. Her frustration was keen. Sometimes deliberately, sometimes out of control, she threw tantrums, defying mother, immune to physical pain. In the periods between the calls, father was not to be mentioned. Gradually, B learned to sit in silence. She recalled an early split in personality: When she was four years old, on ending the nursery school year, she said "goodbye" not to her beloved school, but to the "other" B self whom she left behind there, sitting on a window sill.

B was the most needy and demanding patient I can recall. There were (not surprisingly) frequent phone calls between sessions. I was helpless to diminish them. I interpreted her possessiveness of me, her rivalry with my wife for my attention. She insisted her need for me was real and legitimate. Since this was early in my career, I was also patient and tolerant, "understanding" her need as a result of victimization. I made no demands. I tried mainly to identify feelings and link her body and mental experience, later to link both to interpersonal situations and to life issues. She idealized me, gradually humanized me, always sexualized me. Eventually, she was able to (re)-experience anger; almost never directly at me.

My clarifications and linkages seemed to help her; she went to work on them. My infrequent interpretations were eagerly discussed and processed, with no observable impact except to increase her already excessive psychological-mindedness and obsessive search for ultimate meanings. Later, I shared feelings, including my helpless frustration at her panicked calls. She sympathized with me and stopped calling. She no longer felt the need to hear my voice! In part therapy could be seen as attachment building and gradual weaning. At the end of therapy, she had grown beyond the deepest dependency on me. She got a nonreligious job and was able to marry a stable man. No longer a compliant automaton, her sexuality was more her own, and psychosomatic symptoms significantly lessened.

Her period of most intense trauma was from three to five, when father was away, the height of the Oedipal period. Her tender feelings for him were ungratified and mother's oppression caused her to be lost as a loving object as well. After a mighty protest, she automatically complied with mother, and splitting of personality ensued: between the observing child and the feeling child, between the assertive proselytizer

and the compliant automaton, between the religious saint and the perversely sexual sinner.

Anticipating Anna Freud's (1946) discussion of identification with the aggressor, Ferenczi stresses the guilt-induced split of "innocent-culpable" in the vulnerable child. He points out that some children become defiant, but splitting is involved here as well, so that they are unable to account for the reasons for the defiance. He warns parents, analysts and teachers "to be constantly aware that behind the submissiveness or even the adoration … of our children, patients and pupils there lies hidden an ardent desire to get rid of this oppressive love." We raise the personality to a higher level if we help patients give up the pathological identification and "ward off the overburdening transference."

"Also unbearable punishments lead to fixations." There is a second phenomenon which often springs from a trauma: the "surprising rise of new faculties … a traumatic progression … a precocious maturity." "The fear of the uninhibited, almost mad adult, changes the child, so to speak, into a psychiatrist and, in order to become one and to defend himself against dangers coming from people without self-control, he must know how to identify himself completely with them." I believe this development, the child becoming "psychiatrist, " parent and caretaker to his parent(s), is one that can also develop early in life, without extreme trauma, but rather by repeated, gradual induction and influence by a parent upon even an infant or toddler whose constitutional type permits it. Stern (1985) describes examples of such compliance and complementarity in mother-child interaction, with resultant inhibition of certain idiosyncratic activities of the child, and preferential development of certain adaptational skills, e.g. entertaining mother. How much sympathy and empathy the little child feels is a moot and arguable point; but one which is being examined of late, especially in reference to the development of caring behavior.

It is my impression that such caretaker personalities, with character traits of seriousness and obsessionality, and tendencies towards a "Jesus Christ syndrome" of living to undo or assume responsibility for others' sins, evolve more from the seemingly minor and subtle (read: inattended to) oppressions of everyday life than from discrete major traumatic situations. In these ego-syntonic caretakers and caregivers, there may be concomitant restriction of personal assertiveness and goal-directedness. Their split-off or underdeveloped anger, assertiveness and entitlement are often inaccessible to consciousness and unavailable to self-expression, absent successful therapy, unless they exist in identification with and in support of a valued cause or ideal. It may be that more overt and flagrant punishment and unfairness, administered over time, rouses more intense anger and resentment, which then become the nucleus of better-developed split-off tendencies or personality fragments.

We suspect that the more intense and extreme the parental stimulation, the more intense and extreme the tendencies to identify and to disidentify. In The Invulnerable Child (Anthony and Cohler, 1987) clinicians and researchers examine the lives of children who grew up with the stress of mentally ill and/or abusive parents, and who not only survived, but succeeded in coping with life with a minimum of distress or personal vulnerability. Denial, detachment and emotional distancing were some of the more successful coping mechanisms. Some children had a perspective which either minimized or contained the threat in a larger world-view, not unlike the hero of the movie, "My Life as a Dog, " who consoled himself with the thought, "it could always be worse." Some of the most unshakeable people were not intimate in their relationships. They never permitted deep caring or dependency to develop. Other researchers are rediscovering links between violent childhood abuse and personality splitting, which, as Ferenczi indicated, can progress to fragmentation and atomization of personality, and the development of separate personalities who do not know each other. The literature on such multiple personalities is growing both in the professional and popular press.

Ferenczi closes by sketching a "third method of helplessly binding a child to an adult. This is the terrorism of suffering." "A mother complaining of her constant miseries can create a nurse for life out of her child, i.e. a real mother substitute, neglecting the true interests of the child." As Sullivan spoke of the induction of anxiety from mother to infant, so "depression can be taken in along with mother's milk" (Forrest, 1985). Ferenczi spotlights this deadly and stultifying paralysis of the child's true self and the forced creation of a false, symbiotic caretaker personality.

Patients who have blocked out of memory or denied the significance of (disavowed, as Basch (1983) puts

it) past abuse—physical, sexual, emotional—not infrequently engage in therapy but subsequently develop an impasse of the negative therapeutic reaction type. With a number of these people I have been able to stop, reflect on and change my inner stances and outward behavior, with corresponding positive changes in my patients. Sometimes I have shifted from being seemingly calm and cool to an overt plea for mutual examination of our interaction and a search for possible offending elements in my attitudes. This has enabled a patient to come around and work collaboratively with less depression and more confidence and zest (Zaslow, 1985). I have stepped back from an overly friendly, casual and conversational approach, which tended to obscure slights or rebuffs, and conveyed smugness or self-congratulatory attributions. More often changes are gradual and complex, with shifts back and forth, patches of light and fog, touching and disconnections. These comments have a familiar and mundane generalization, which I have intended to reflect some of the non- threatening flavor of working with those with certain intact defenses which are self- containing and self-protective.

Not so easy and vague has it been to relate to those people who recall and signify their experience and history of abuse right at the start of treatment. These people are often hyperalert and hypersensitive. Thin-skinned, they are aware of hurt, hostility, depression. Their therapies, aborted or extended, have been problemmatic and challenging from the initial contact. They have put me on the spot with the demand: "How will therapy help?

How can you help me!"

I recall a number of women in their twenties or thirties, who with hypervigilance, spoke directly and assertively, detailed their pain and problems precisely, with a "too knowing" attitude and a controlled hysteria. They knew their sufferings related to their traumatic pasts. They had not been helped by previous psychotherapy, behavior therapy or medication. They suffered anxiety-panic and/or depression with or without crying spells, difficulty regulating appetite and weight, distorted body image and conviction of personal ugliness. They critiqued themselves and their loved ones with a merciless honesty and exactitude. They knew their inner sense of badness was their worst problem. Most related it to emotional abuse at the hands of mother, even those who were sexual victims. Fathers were scorned more for self-centeredness, indifference or weakness than for damaging their self-esteem. How could therapy help? How would I help them?

Being helped ultimately meant feeling better, shedding symptoms of dysphoria and lack of control. No consistent helping images or relationships emerged from the past, except those which validated their performance and achievement, e.g. school marks, athletic prowess, dramatic and artistic merit. The supportive people were always not family members. So exploration of "help" left a void. I explained it was generally easy to link problems with past events and current relationships, even self-evaluations. They had done much of the insight work already. Change was a different matter. It involved a combination of developing tolerance for painful affect and getting involved in therapy. Sooner or later we would find ourselves in conflict, or a muddle, or an impasse. Somehow, we would work out of it, and from this change would emerge, along with new perspective. Most were sceptical. A few began treatment. Others wanted examples, and examples were given; which were uniformly unsatisfactory. I suggested the possibility of anxiety accompanying hope (Boris, 1976) or related to taking in something good. (I was tempted to ask if they were checking to see the milk wasn't poisoned; but I didn't think they regarded therapy as milk.) I had the same experience for those who asked about medications. When potentially indicated, I discussed medication fully. Most nonetheless rejected medications out of hand. A few "yessed" me (though I had not recommended medication, rather outlined pros and cons), took a prescription and didn't fill it. The few who tried the medication had an immediate idiosyncratic "bad" reaction (dysphoria, upset thinking) and stopped promptly. And there were a couple who continued for weeks with medication without benefit. Early in treatment I generally did not feel right about interpreting the aggressive turnabout: their putting me in a position wherein I could not please them, as they had been unable to please others. (Now I would explore this early on.) Later in therapy, such an approach, combined with my brief, but sharp exclamation that I'd been (ab)used, was well received, and permitted a different vantage point from which to examine hope, let-down and reconnection. Some dropped out early because I overidentified with their suffering or tried too

hard to get close. Others left because I forgot something or made a comment to a relative who called. These offenses were unforgivable, the damage irreparable.

These women stressed the degree to which their mothers were overtly and unreasonably critical, contemptuous, rejecting and unsupportive of anything good in them as children, adolescents or adults. Stories abounded of mothers' disbelief of their plight, of mothers' preference for their brothers (e.g. funding a ne'er-do-well brother's college education, while denying a valedictorian sister, buying violent brother a car and refusing a first-chair violinist her instrument). The father's role was usually glossed, poorly conceptualized. A shadow figure, he was unavailable to help mother and daughter "cut the cord" of hostiledependency. Perhaps the fact of the exclusion of awareness of father in the Oedipal triangle can better be linked with the patient's difficulty in conceptualizing and believing that therapy can help.

Recent attempts at synthesis within both psychoanalytic theory and technique promise increased therapeutic effectiveness (Cf. Havens, 1986). Understanding paradoxical transferences and interpreting them without resort to counter-paradoxical maneuvers keeps the analytic frame intact (Anzieu, 1986). Patients assign us many roles within the intermediate-transitional space of the analytic screen. At times we may have to play out some of these roles in order to hold more regressed patients (Winnicott, 1986). Openmindedness permits the possibility of play—play with theory, play in therapy. Play, in turn, creates new possibilities. It is an area of experience sadly missing in the lives of these seriously traumatized and deadly serious people. Play creeps in as we try out new ideas and identifications with our patients, as did Ferenczi. When they pick up on our change and flexibility, they develop the freedom to test new modes of relating. They ease the rigid tie to the traumatic past, diminish repetition-compulsion and identification with the aggressor, cut the internalized hostile umbilical cord. They bring forward new and freer selves, more able to speak their own language with tenderness and passion.

One thing is clear. The experience of reading Ferenczi's classic is a reintroduction to one of the field's most original and seminal minds. Going back to this paper, in the light of current reading and practice, is like revisiting the headwaters of a turbulent, broad, everflowing, refreshing river.

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