WHO GIVES BACK THE VOICE OF THE PATIENT? A CRITIQUE OF THE FREUDIAN THERAPEUTIC ATTITUDE.

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ABSTRACT:

The present article lays out the difference between two psychotherapeutic paradigms: one silencing mental patients, the other one intending to give them back their voice. According to Foucault, medicine from the 17th century gradually breaks the dialogue between madness and normality and the language of psychiatry becomes the monologue of the reason. Freudian psychoanalysis was the first attempt to break this silence. Freud's communicative therapy brought back madness to the field of discourse and showed the possibility of dialogue with abnormality. In many case studies, however, Freud authoritatively pushes his own understanding over his patients. Psychoanalysis seems liberative; however, there is a perceptible tension between the Freudian theory and the practice. I used Sándor Ferenczi's oeuvre to propose a synthesis of the original Freudian intention and the analyst's hierarchical position in practice. He also focused on the communicative potential of the therapy, but he experimented more broadly to find the most suitable form of doctor-patient relationship. Hence, Ferenczi's oeuvre opens up alternative therapeutic attitudes and allows a more nuanced implementation of Freud's original thoughts.

Keywords: psychoanalysis, talking therapy, communication, mutual recognition, mental patients

RESUMEN:

Este artículo presenta la diferencia entre dos paradigmas psicoterapéuticos: uno que silencia a los pacientes mentales y otro que busca devolverles su voz. Según Foucault, la medicina a partir del siglo XVII rompe gradualmente el diálogo entre la locura y la normalidad, y el lenguaje de la psiquiatría se convierte en el monólogo de la razón. El psicoanálisis freudiano fue el primer intento de romper este silencio. La terapia comunicativa de Freud devolvió la locura al ámbito del discurso y mostró la posibilidad de un diálogo con la anormalidad. Sin embargo, en muchos estudios de caso, Freud impone autoritariamente su propia comprensión sobre sus pacientes. El psicoanálisis parece liberador; sin embargo, hay una tensión perceptible entre la teoría freudiana y la práctica. Utilicé la obra de Sándor Ferenczi para proponer una síntesis de la intención original de Freud y la posición jerárquica del analista en la práctica. Ferenczi también se centró en el potencial comunicativo de la terapia, pero experimentó de manera más amplia para encontrar la forma más adecuada de relación médico-paciente. Por lo tanto, la obra de Ferenczi abre caminos hacia actitudes terapéuticas alternativas y permite una implementación más matizada de los pensamientos originales de Freud.

Palabras clave: psicoanálisis, terapia verbal, comunicación, reconocimiento mutuo, pacientes mentales

1. INTRODUCTION

In Freudian theory, neurotic symptoms work as a sort of language. To be more specific, symptoms are functioning like signs in verbal language, meaning that every symptom is refers to something else. In most cases, they refer to patients' past emotions, experiences or trauma that the subject cannot cope with and, therefore, they get transformed by the psyche. In this transformation, the meaning seemingly gets lost for the subject (Breuer & Freud, 1895/1995; Freud, 1901/2006, p. 212). As Lacan (1966, pp. 364-384) later explains, the symptom is a message that ignores its own writer, as it goes beyond the subject's rational world.

The most important intention of psychotherapy is to find reason behind seemingly irrational bodily or neurotic symptoms. Freud forced his patients to understand by themselves the repressed content of their symptoms, because they were the ones who produced those very symptoms. As symptoms are the result of the subject's individual self-defense mechanisms, they are unique psychic formations and their structure depends on the nature of the subject's past experiences, habitus, intersubjective relations, socialization, and on the actual socio-cultural setting (Freud, 1901/2006, pp. 212-224). Consequently, not the psychiatrist, nor the psychoanalyst, but only the patients themselves could decode the message of the symptom.

In a dialogue accompanied by analysis, the patients could recognize the cause of the psychic tension that produces the symptoms. Communication, therefore, is a key element of psychotherapy, wherein the analyst and the clients search together for the meanings of the symptoms. Through the dialogue, they could put the traumatic events into coherent narratives in which the trauma could become meaningful and acceptable for the patients. I believe that one of Freud's greatest insights was the realization that communication with mentally ill patients is not just possible, but even necessary. While the former psychiatric paradigm had treated patients as passive objects of medical treatment, Freud's method gives them back their subject status through the right to speech. The psychoanalytical method hence seems liberative; however, there is a perceptible tension between the Freudian theory and the practice as described in his case studies.

The main object of the present article is to point out this tension between the original Freudian intention and the practical implementation of his work. In order to achieve this, the first section describes the paradigm of the classical psychiatry through Michel Foucault's writing on psychiatric power. The second part explains how the method of Freudian psychoanalysis changes the subject status of mental patients through communicative therapy. Following that, through Freud's famous Dora case, I will point out the gaps between his theory and the practice. The last section presents the ideas of Sándor Ferenczi, Hungarian psychoanalyst and contemporary of Freud. Ferenczi also focused on the communicative potential of analytic situations; however, he experimented more broadly to find the most suitable form of doctor-patient relationship. In my opinion, Ferenczi's oeuvre opens up alternative therapeutic attitudes and allows a more nuanced implementation of Freud's original thoughts.

2. THE PSYCHIATRY OF THE 18TH CENTURY

As Michel Foucault (1977) has pointed out, first, in Discipline and Punish, the body is not naturally existing, but produced through different discursive practices, mediated by institutions like the state, the law, schools, prisons, clinics, or, in a more abstract sense, the family, race, gender, sexuality. Therefore, the body is a surface on which the norms of the actual socio-cultural establishment have

been written (Foucault, 1977). Several practices are responsible for the creation of this corporeality, and medicalization is one of these practices. In this sense, psychopathology is the crystallization of culture that creates a certain kind of body or subjectivity. To understand the medicalized subject's social status, we have to unfold the relation of normality and abnormality.

The socio-culturally determined system of norms marks the limits of discourse[1]. Those subjects who conform to these norms can take part in the discursive field, which means that they have certain rights to shape it. In contrast, people who are considered abnormal get pushed to the margins of society and their rights to shape social reality are restricted. These people, for example, criminals or

people with mental illnesses, have to go through different disciplinary practices such as imprisonment or hospital treatment to reintegrate and receive back their full-right subject status.

Foucault analyses archeologically (as he calls his historically and culturally based investigation method) how the notion of abnormality is born in a certain point of history. *In Madness and Civilization: A History of Insanity in the Age of Reason*, Foucault (1965) argues that the modern definition of madness as abnormality is a social construction, which stems back to the 17th-18th century. Before that, the social status of the "mad men" was not marginalized, but this category was a constitutive part of the society. One of his examples of this kind of madness is the Shakespearian fools: these characters usually stand for a metaknowledge

about the dramatic situation. However, the overall rationalization project of the 17th-century enlightenment established a conceptual distinction

between normal and abnormal. Following this important break, those people who could not conform to the social norm were disqualified as unreasonable, therefore leading to their exile from society as a possible source of danger. Foucault (1965, p. 61) calls this period the "great confinement", because the first asylums for mentally ill people were created at that time. These early disciplinary institutions

for mentally ill people can thus be considered as the materialization of the conceptual distinction between normal and abnormal.

Creating mental asylums and certain medical practices for mentally ill people were a part of the normalization project of the 17th century. Similar institutions, before the period of Enlightenment, were rather shelters for people rated as insane, lunatics, criminals, syphilitics, beggars, disabled people, or elderly men, in short, for those who had a potential to bring disturbance into their surrounding environments. After the restructuring of the institutions, they served as a space of exclusion, internment, and assimilation. To put it in different words, these people were seen as dangerous, immoral, useless, and undesirable for the society, which legitimated the confinement and overall supervision of the outcasts. Consequently, from the 17th century, mental asylums have not dealt with the abnormal people as independent subjects, but rather like existences somewhere half way to the norm. That is how medical institutions started to desubjectify patients and to deprive them of the right of reason. Medicine from the 17th century gradually muted, sanctioned and exiled abnormality from the social sphere (Foucault, 1965). By the end of the 18th century, the dialogue breaks between madness and normality. As Foucault (1961/2009) puts, the language of psychiatry becomes the monologue of the reason about madness:

> modern man no longer communicates with the madman [...] There is no common language: or rather, it no longer exists; the constitution of madness as mental illness, at the end of the eighteenth century, bears witness to a rupture in a dialogue, gives the separation as already enacted, and expels from the memory all those imperfect words, of no fixed syntax, spoken falteringly, in which the exchange between madness and reason was carried out. The language of psychiatry, which is a monologue by reason about madness, could only have come into existence in such a silence.[2] (pp. xxvii–xxxix.)

According to Foucault, the practice of the Freudian psychoanalysis was the first attempt to break the long silence of the 18th century madness. Freud's communicative therapy started to listen to the voice of those people who were considered unreasonable by the institutional psychiatry. Therefore, Freud brought back madness to the field of discourse and showed the possibility of dialogue with abnormality (Foucault, 1965, p. 159). By this act, psychoanalysis questions even the solid category of the abnormal. Through communication, the before muted patients could rediscover their own voice and, therefore, reconnect to the social sphere of which they were exiled. The mere fact that a representative of an institution could acknowledge the voice of mentally ill people already represented their automatic reintegration into the world of normality

One of the basic differences between modern psychiatry, as described by Foucault, and Freud's communicative therapy is the communicative potential of the patient. For psychiatry, the symptom was considered a sign of abnormality that becomes visible through the patient's physical being, while, for Freud, the communicative potential is driven by the symptom. The main goal of psychiatry is the elimination of these symptoms, or, as Foucault (2009) puts it, it has to mute them. For Freud, on the contrary, symptoms have a different meaning. He believed that these are signs, communicative formations, which circumvent verbal language. As they have expressive potential, psychoanalysis has to put them into dialogue to unfold their meaning. In the next part, I will extend on Freud's theory on symptoms and how his insights created a new form of talking therapy.

3. SIGMUND FREUD AND THE TALKING THERAPY

The symptom has different meanings in the field of medicine. One is a biological one: pain in the body refers to a dysfunctional mechanism and the relief from the symptom means healthiness, as the body functions in the proper way. Therefore, for human medicine, the main goal of any therapy is the elimination of the symptoms. As soon as the symptom disappears, the patient becomes healthy. This described logic applies also to the Foucauldian description of psychiatry, in which the most important step is to mitigate the symptom, even if it is not bodily, but neurotic. It is this very point into which the Freudian analysis intervenes.

Freud's revolutionary thought was that the symptom has a kind of communicative potential. Lacan, after Freud, calls this potential le vouloir-dire, the desire to say something (Lacan, 1966, p. 83) To give an example, from the psychoanalytical standpoint, when we make a mistake while we speak, it is actually a repressed thought, psychical action or memory that would like to come to the surface or express itself. In the case of the slip of the tongue (parapraxis), we have to hypothesize a repressed message. Dreams are another field of these cases of „want-to-say", according to Freud. Dream-work expresses those contents of the psyche through images instead of words (Freud, 1899/2010). Symptoms, according to Freud (Breuer & Freud, 1895/1995), work through the same mechanisms as parapraxis or dreams, as they express repressed contents of the psyche, but, instead of a manifestation on the level of language or images, they show on the level of the body. Freud (1920/2012) believed that the talking therapy of psychoanalysis is a way to reveal this non-obvious relationship between the symptom and the repressed content. In the dialogue of the analysis, the subject has to reveal himself/herself the meaning of the symptom by putting it into a narrative structure. Therefore, the function of the analysis is to ask about the meaning of the symptom in the context of the client's life (Freud, 1920/2012).

The most important intention of psychotherapy is to find the reason in the seemingly irrational symptom by forcing the patient to understand the repressed content. Such an approach is necessary if we regard the symptom as a message that ignores its own writer, as it goes beyond the subject's rational world (Lacan, 1966). In the dialogue of the analysis, the patient has to recognize the cause of the psychic tension that produces the symptoms. Breuer and Freud (1895/1995) assume that, in most cases, it is the tension between the superego and those instincts and desires that count as obscene in the socio-cultural order (for example, in the case of hysteria, where the tension was grounded in the difference between the socially determined female roles and the real needs of women). In this sense, the analyst has to ask about the patient's desires and, thus, as the patient is forced to pronounce them, they are freed from the super ego's censorship.

We should regard the original Freudian analysis as a hermeneutic work, wherein the analyst and the client search together for the meanings of the symptom. Through this work, they can put the traumatic event into a coherent narrative, which leads to a reworking of the trauma into a meaningful and acceptable state for the patient. Furthermore, the method of talking therapy creates a somewhat equal relationship between analyst (institution) and patient (marginalized subject), as they need to work together and both actively participate to find the meaning of the symptom.

4. A CRITIQUE OF THE FREUDIAN ANALYSIS

As outlined about, in theory, the Freudian therapy is a joint work of analyst and patient, but it is crucial to say that it has many implicit risks. The analyst, as the gatekeeper of the institution of psychoanalysis, represents the social norm. Therefore, he/she implicitly could channel the patient's desires into the socially acceptable system of values. As Foucault emphasizes in his critique (Foucault, 1965, p. 159) and as I will outline in detail below, Freud pushed his own narrative over the patient's one in multiple cases. Therefore, we can start from the assumption that the therapy remains the analyst's monologue about the patient.

Most of Freud's case studies are composed as a kind of detective narrative, in which Freud, as a wise figure of science, deciphers the client's case, regardless of the patient's intention. In many case studies, it is not the patient, but Freud who creates the narrative out of seemingly diffuse elements of the subject's life story. Doing so, Freud's practice stands in opposition to his own intention. He liberates his patients from

their former determinations (subjective beliefs, family, social norms), but immediately traps them into his own narrative. Therefore, the patients remain the passive objects of the analyst interpretations, while the analyst becomes the only and authentic representative of the truth.

One of the most blatant examples of this process is Freud's famous Dora case (Freud, 1905/1997). The teenage aged patient was diagnosed with hysteria in 1900. Her most manifest symptom was the so-called hysterical aphonia, a type of somatoform disorder when the patient suffers a loss of his/her voice. Dora starts to produce her hysterical symptoms after a family friend, Mr. K., an older man, constantly seeks to get closer to the girl, as he often accompanies her on walks outside the town and gives her small gifts. The presence of Herr K. is getting more disturbing for her; therefore, she tells her father about the family friend's actions. Her aphonia appears after nobody in the family believes her.

Dora spent 11 weeks in analysis with Freud; however, he did not care much about Dora's case, as shown by his description of the case in his manuscript as an insignificant petite hysteérie, that he takes only because of his more extensive research on hysteria.

> No doubt this case history, as I have so far outlined it, does not upon the whole seem worth recording. It is merely a case of 'petite hysteérie' with the commonest of all somatic and mental symptoms […] More interesting cases of hysteria have no doubt been published, and they have very often been more carefully described; for nothing will be found in the following pages on the subject of stigmata of cutaneous sensibility, limitation of the visual field, or similar matters. I may venture to remark, however, that all such collections of the strange and wonderful phenomena of hysteria have but slightly advanced our knowledge of a disease which still remains as great a puzzle as ever. (Freud, 1905/1997, pp. 23-24.)

During the therapy, Dora tells Freud about Herr K. and her suspicion that her father implicitly offered her to the man as a compensation for his secret affair with Herr K.'s wife, Frau K. Furthermore, Dora had the conjecture that Herr K. tried to get close to her from her early childhood, even if she had no clear memories about it. Dora's suspicions supported Freud's assumptions about the mechanism of repression, therefore he tried to surface these memories through his new method, the dream analysis.

As result of such a dream analysis, Freud (1905/1997) concludes that the cause of Dora's symptoms is actually the repressed sexual desires for her father and for Herr K., as another father figure in her life. The core of Dora's hysteria is that she could not face with her own attraction to the man.

> If we have rightly guessed the nature of the imaginary sexual situation which underlay her cough, in that phantasy she must have been putting herself in Frau K.'s place. She was, therefore, identifying herself both with the woman her father had once loved and with the woman he loved now. The inference is obvious that her affection for her father was a much stronger one than she knew or than she would have cared to admit: in fact, that she was in love with him. (Freud, 1905/1997, p. 56)

According to *The Interpretation of Dreams* from 1899, after the patient realizes himself/herself the repressed content, the symptoms, as they are caused by the content, should automatically disappear, as there is no need for its mediation after the recognition at the conscious level (Freud, 1899/2010). However, Dora's symptoms did not disappear and she left the therapy after a short time. Regardless of the failure of the therapy, Freud (1905/1997, pp. 102-112.) insisted that he had the potential to heal Dora if the girl had not had refused his help.

Dora's case study gives insight into the practice of the early analysis and the mechanism of the dream-analysis as a form of hermeneutics. As the case shows, Freud's attitude and interpretations were very problematic. From the very first moment, Freud regarded Dora's case as an ordinary and unimportant hysteria and he took it only for his own professional purposes, not because of the desire to help or heal the

girl. Therefore, Dora had to confess her most intimate feelings to a person who was not interested in her trauma, but rather her symptoms, as scientific objects.

As Helen Cixous (1986) reinterprets the case in her essay from 1975 (1986, p.17), Dora's aphonia can be explained through the lack of belief from the side of her family and the disregarding of her voice. Herr K. and her father saw her as a liar who only fantasizes the seduction. Similarly, Freud also pushed his own understanding over the girl's interpretation, namely that she herself desires Herr K. It may seem that Freud explained her dreams in this specific way to justify his own theory on the 'Oedipal conflict' and the 'seduction hypothesis'. To justify his theory, he ignored the fact that the girl was a victim of sexual harassment, which alone might already be enough to cause her hysterical symptoms. Dora tells her story, but nobody pays attention to her and, even after she could not continue the therapy under these circumstances, Freud blamed her for the failure of the analysis. In Dora's case, we can see how easily the therapist can push his/her own interpretation over the patient's one. As Foucault (1965, p. 159) puts it, even if the communicative method has the potential to give voice to madness, this potential gets lost immediately when the therapist recreates the hierarchical relationship between doctor and patient.

After a few decades of institutionalization of the psychotherapy, many theoreticians, like Foucault (1965, 2003), Deleuze and Guattari (1972) or Lacan (1973), criticized the way the official, applied, treatment works against the autonomy of the patients. The main problem they mention is that the talking therapy recreates the restrictive power of the psychiatric institutions. The professionals' interpretations are still focusing on the re-socialization of the marginalized subjects, but without questioning the norm itself. Therefore, psy-sciences do not intend to find the meaning of the symptom, like the original therapy intended, but they focus on the abolishment of the symptoms, and the normalization of the patient. In this sense, normalization has to be understood as mediation of the dominant value system and as propagation of a one-dimensional notion of normality through therapy.

According to some perspectives, including those of Deleuze and Guattari (1972), if the therapy does not try to understand the individual meaning of the symptoms and avoids the necessary hermeneutic work, it can never find a long-term solution. Furthermore, if the therapist acts like a wise father, the gatekeeper of normality, in the name of unquestionable facts, he/she reproduces the inequality inside the therapeutic situation as well (Foucault, 1965, 2003). These factors question the healing potential of the communicative treatment, as they show the limits of the treatment for understanding the real problem of the subject. But how can we avoid the objectification, misinterpretation, unequal power relation in therapy? What could be an approach that a therapist can follow to avoid the described pitfalls? The last part of this essay presents an alternative way of the intersubjective relationship between the analyst and the patient by drawing on the oeuvre of Freud's contemporary, Sándor Ferenczi.

5. SÁNDOR FERENCZI AND THE IMPORTANCE OF TRANSFERENCE

Sándor Ferenczi is a Hungarian psychoanalyst, who became the Freud's student and friend in his early twenties. Their relationship started with the exchange of letters, lasting over years. They developed a very close friendship as they worked on many cases together and Ferenczi saw a kind of father figure in Freud, as he wrote in his diary (Ferenczi, 1988). Later, Ferenczi founded his own circle of psychoanalysts in Budapest, where he was a relatively famous leading intellectual. The friendship of Freud and Ferenczi broke after Ferenczi openly questioned some basic ideas of psychoanalysis, including the Oedipal complex, and after he also experimented with a form of the therapy against Freud's will. The Freud's circle publicly turned away from Ferenczi and their joint work ended. His ideas remained forgotten for decades for institutional reasons, namely because the psychoanalytic society excluded him. His thoughts have been re-discovered only since the 1990s (Berman, 1996; Szecsődy, 2012).

In this section, I focus on the difference between Ferenczi's and Freud's therapeutic approach. For Ferenczi, the intersubjective relationship is the essence of the therapy, as he had written in his clinical diary (Ferenczi, 1927/1980c, p. 84). In contrast to the Freudian case studies, these records are not composed and stylized, but contain Ferenczi's emotions, subjective experiences, doubts, and mistakes during his

experimentation. Therefore, the clinical diary does not give a well-formed and descriptive theory on the form of the therapy, but offers ideas. It is an important fact that Ferenczi made mistakes in many cases, but it is remarkable though that he was very reflective of them. His standpoint is especially important, as it represents an ethical account by a therapist, for which reason I would like to put his approach into a dialogue with the Freudian sentiment.

Ferenczi closely followed Freud's theory, but constantly experimented with the form of the therapeutic relationship and made various attempts to change the analyst's role. One of his main questions was the role of transference and counter-transference in the intersubjective relation of doctor and patient (Ferenczi, 1926/1980b, 1927/1980c). As transference, we understand the projection of the patient's past feelings into the actual situation of the therapy and into the subject of the therapist, including rage, hatred, mistrust, parentification, erotic attraction, or dependence. According to Freud, transference is the greatest threat and the best tool for the treatment (Freud, 1916-1917/1991, p. 496): the greatest threat, as an obstacle to the joint work of doctor-patient, but the best tool to understand the client's past experiences and feelings. Countertransference is the same mechanism, but with a different directionality, being the analyst's projection of his/her personal feelings into the client. Even if countertransference might also help the therapist to understand the subject's situation, it is rated to be more dangerous than transference. Countertransference could easily distort the therapist's objective relationship towards the patient and, through that, jeopardizes the success of the therapy, which means that professionals have to overcome their personal feelings or, in case they cannot do that, to stop the therapy with that specific client. Psychoanalysis emphasizes the emotional abstinence for the therapists, which means the full control of their emotions and feelings within the frame of the therapy (Freud, 1916-1917/1991).

Ferenczi had multiple problems with this abstinence. Through his clinical diary, we get a detailed picture of his experiments with the dialectic of transference and countertransference throughout his whole life. As he writes, he refused to "maintain the cold superiority of the analyst" (Letter to Freud, December 3, 1911 in Brabant, Falzeder & Giampieri-Deutsch, 1993, p. 316). This cold superiority could be understood as a bigger barrier to the successful therapy in comparison to the supposed barrier of the emotional distortion. He emphasized that the therapist's feelings are useful, as the client recreates his/her past emotion through transference in the artificial situation of the therapy. According to Ferenczi, we could create such an environment only if the analyst is concerned with the trauma as well, which makes countertransference necessary in a certain way. As transference helps the patients to understand themselves better, countertransference helps the professional to understand the client's trauma better (Haynal, 1997, Heiman 1950).

Ferenczi adds the personal relationship between client and analyst to the core of the treatment, which makes him, in the words of Imre Szecsődy (2012), the first intersubjectivist. A type of therapy in which intersubjectivity is central is an "active technique", as both participants take part emotionally and the analyst constantly looks for the better method that suits for the patient (Bálint 1968). Ferenczi emphasized the importance of the evolving relationship between client and analyst and the undeniable fact that this relationship influences both participants. Transference and the real relationship become

intertwined during the psychoanalytic process, where not only the client, but also the analyst becomes involved and where, slowly, both became part of each other's life stories. This process is inevitable, even if professionals would like to repress it.

Through such an approach, the relationship would become the center of the analysis, not the mere subjectivity of the client. Introjection, projection, transference, and countertransference are shared experiences that have specific functions in the therapy. Therefore, it is important not to be authoritative, but tentative in relation to the patient. Humility has to be sincere, not artificial, if the analyst would like to preserve equality (Szecsődy, 2012, pp. 6-7). According to Ferenczi, the recognition of countertransference can help the mutual recognition, leading to a greater openness of the client. The therapy reconstructs past feelings within the emotional experience of the here and now of the therapy, which allows, afterwards, to reintegrate the part of the personality that has been split off by the trauma. This is the "gold of psychoanalysis", the personal relationship between client and analyst, as Ferenczi puts it (apud Szecsődy, 2012, p. 7).

Ferenczi's idea of reshaping therapy raises many methodological questions. The therapeutic abstinence, even if discovered as problematic, has a function from a certain medical standpoint. However, Ferenczi did not deny the necessity of some stable therapeutic frame and he emphasized the importance of the therapy for therapists as well. According to his approach, the analyst has to constantly oscillate between empathy and self-observation before forming an opinion. His/her position is of an insider and outsider at the same time. The therapist has to rely on his/her common sense to adapt to the patient's needs. Following Ferenczi's thoughts, all analysts should undergo analysis as long as they offer it to their patients. Self-knowledge helps the therapist to abstain from narcissistic gratification and to realize his/her possible mistakes (Ferenczi, 1927/1980c, p. 84).

In many cases, when the analysis is not successful, the analyst has to check if that form of therapy meets client's needs. As Ferenczi puts it in his medical diary, there is no incurable case, but the lack of skill on the side of the analyst. Therefore, the analyst has to be capable to change the technique, not blame the analyzed similarly to the way Freud blamed Dora for the lack of the success of therapy. Ferenczi (1931/1980a, pp. 128-129) summarizes the underlying thought in the following words: "As long as the patient continues to come at all, the last thread of hope has not snapped".

6. CONCLUSION

I have laid out the difference between two paradigms: one silencing mental patients, the other one intending to give them back their voice. Based on that, the present article has shown the immanent tension inside the Freudian theory and its application. Following Foucault, Freud, after he gave back the voice of his clients through talking therapy, immediately trapped them within his own narrative. I used Ferenczi's oeuvre to propose a synthesis of the original Freudian intention and the analyst's hierarchical position in practice. The most important lesson we can learn from Ferenczi is his commitment for altering the usual technique and for adapting to the personality of the patient. Inherent in this, is a tension between two opposing approaches: experimenting versus upholding doctrinaire knowledge. For him, the preservation of the patients' subjectivity was more important than to maintain the illusion of objectivity. The highest goal of the therapy is to heal, not to reproduce the unquestionable authority of the doctor and the institutional power of psychoanalysis. Without such a perspective, the therapy loses thus the conversation that Freud meant to set up.

In the history of psy-sciences after Freud, several attempts were started to solve the unequal doctor-patient relationship. One of them was Carl Rogers' humanistic approach. In the 1950s, he invented the person-centred therapy, a non-authoritative approach, where the patient is the one who leads the discussion and, therefore, clients could discover themselves their solution. The therapist acts more like a facilitator who does not judge and does not move the conversation in another direction. It is the self-discovery of the client which the therapist does not interrupt or interfere with, but, on the contrary, which he/she encourages and supports (Rogers, 1951). While offering an interesting shift of perspective, unfortunately, Rogers' method does not consider the role of the analyst and the evolving relationship between the doctor and patients. Closer to Ferenczi is the intersubjectivist psychoanalysis of George Atwood and Robert Stolorow from the early 80s. This method suggests that every interaction is contextual; hence, the analyst and patient could not be separated from each other, as they are always mutually influencing each other (Atwood & Stolorow, 2004).

While these days many tools to balance the doctor-patient relation on the field of psy-sciences are introduced, Ferenczi remains the first to have seen these problems at the dawn of psychoanalysis. As psychiatry muted its patients for a long time, Ferenczi was also silenced by the institution of the early psychoanalysis. It is still ahead for us to re-discover his thoughts through a deeper analysis of how his ideas are important in the healing process of mental patients.

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Notas al final

1.- Discourse for Foucault is a term for the ever changing historical and social system that produces knowledge and meaning. As he puts, discourse has material effects, producing "practices that systematically form the objects of which they speak" (Foucault, 1972, p. 49). Discourse is a way of organizing knowledge that structures the social reality and its relations by the collective understanding and acceptance of the discourse as a fact. As Foucault (1981) states: In every society the production of discourse is at once controlled, selected, organized and redistributed by a certain number of procedures whose role is to ward off its powers and dangers, to gain mastery over its chance events, to evade its ponderous, formidable materiality. (p. 53)
2.- Preface to the 1961 edition of Foucault's "History of Madness" (Foucault, 2009)