

# **Sandor Ferenczi, A Proto-Rogerian: A Reply to Fred Redekop and Barry Grant**

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I want to express appreciation to Fred Redekop and Barry Grant for agreeing to take on the task of responding to my article. I begin my response by thanking Fred for his favorable review (Redekop, 2010, p. 32-34). There is not much one can write when one receives such kind support. But to stir the pot a bit, I would like to elaborate on one aspect of Fred's review, by making a distinction between Freud the theoretician and the powerful leader of the psychoanalytic movement, and Freud the therapist. During the past year I have taken a course on the writings of the pioneer psychoanalyst, Sandor Ferenczi. Ferenczi is well-known in the history of psychoanalysis since he and Carl Jung accompanied Freud on Freud's ground-breaking trip to Clarke University in 1909 to give the first lectures on psychoanalysis in the United States. Ferenczi was very close to Freud, went on vacations with him and his family, and there was a long and detailed correspondence between the two men. However, when Ferenczi began to articulate his own innovative ideas about therapy, by emphasizing the importance of therapeutic empathy, compassion, and love, he became alienated from Freud and other Freudian analysts (Breger, 2000, p. 349-351; Rachman, 1989; Dupont, 1985). Ferenczi was accused of going too far in treating his patients with warmth and tenderness. However, Breger (2000) wrote, "these accusations were serious distortions of Ferenczi's sincere efforts to open himself emotionally to his patients' experience" (p. 350). It was some of

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Ferenczi's ideas, transmitted by his colleague Otto Rank, and Rankian social workers (Kirschenbaum, 2007, p. 87-88), that made their way to Rogers in the 1930s, and influenced Rogers considerably.

From reading Ferenczi's "Clinical Diary" (1932/1985), I have come to learn that Freud, brilliant as a theoretician and scientist, and powerful as a leader of the psychoanalytic movement, wasn't especially dedicated as a psychotherapist. Some of his own unexplored issues prevented him from being empathic with his patients. In 1897 Freud abandoned his seduction theory, and came to believe that his patient's descriptions of sexual abuse were fantasies, and developed a more constitutional theory of instinctual drives and oedipal erotic wishes as the cause of neurotic suffering. It was Sandor Ferenczi (1932/1949), in his "Confusion of Tongues" paper, which was banned by the psychoanalytic community for many years, who asserted that real trauma, including sexual abuse, was often the cause of psychological suffering. Ferenczi (1932/1985) cared about his patients, wanted to be of help in relieving their suffering, was open and honest in the therapeutic relationship, and didn't want to exercise any power or control over patients.

Freud's failure to understand his own early trauma, prevented him from giving serious consideration to the traumas of his patients. Breger (2000) wrote,

Working with Breuer's cathartic method had brought Freud too close to his own dissociated core of loss, anxiety, and helplessness. ... Though initially drawn to Breuer's cathartic method, he rejected it in favor of his theory of sexuality and his stance as the all-knowing therapist-authority because listening to the agonizing memories of loss and pain related by these patients rekindled his own perturbing memories. To empathize with them, to feel their losses and fears, was not a safe place for Freud; interpreting their sexual instincts and fantasies, and minimizing their traumas, was much more comfortable (pp.121-122).

Breger (2000) also wrote,

Freud ... was committed to his universal theories and never conceived of psychoanalytic therapy in terms of empathy or

dialogue. If patients did not agree with his interpretations, he considered it a sign of their resistance (p. 226).

Freud, innovative as a theoretician and scientist, and an ambitious and powerful leader of a movement, the aim of which was to understand mental life, was, however, limited as a practicing therapist (Dupont, 1985, p. xxiii). Apart from this one elaboration on Redekop's review, I very much appreciate his supportive comments regarding my manuscript.

I want to thank Barry Grant (2010, p. 35-38) for stimulating me to think in more depth about the non-directive attitude and my own practice of psychotherapy. Barry wants to make distinctions between different forms of therapy, and I want to find their commonalities and to integrate them. I am not sure that making distinctions between approaches is more desirable than articulating their similarities, and I imagine both may be helpful in different respects.

Of the various issues discussed in my article, Grant (2010) challenges my belief that the practice of client-centered therapy and self psychology are similar. He asks "what do practitioners of each form of therapy *mean* by empathic understanding and expressing therapist subjectivity? What do they *intend* when they do them?" (p. 36) He cites Brodley (1999, 2006), who "argues that empathic understanding is an expression of the non-directive attitude inherent in Rogers' core therapeutic attitudes, which are based on the value of respect for persons" (p. 36). He further writes "Brodley discourages making therapist-frame responses, such as self-disclosures or observations of the client, because of their risk of harm to clients and proposes guidelines for making therapist-frame responses based on the value of non-directivity (Brodley, 1999)" (p. 36-37). In Brodley's (1999) article she said, "a mean percent of over ten to twelve percent of therapist-frame responses (other than therapist-frame responses to clients' questions) ... probably casts doubt on the therapist's consistency in being client-centered" (Brodley, 1999, p. 25fn).

It is true that self psychologists never discuss the issue of non-directivity. However, I continue to believe that an experienced self psychologist, just like a client-centered therapist, appreciates the need for empathic understanding, minimizes the expression of his or her own unique subjectivity, and, to my knowledge, has no hidden agenda

for the patient. A few years ago I taught a course on Kohut's writings at a self psychology institute, and the emphasis for candidates at that institute was on empathic understanding and limiting the expression of their framework in the relationship. I have quoted (Kahn, 2010, p. 24) Shumsky and Orange (2007), who emphasize the "healing power of sustained, ongoing, attuned mutual regulation" that can be helpful over time (p. 190). I also cited Goldberg (1986), who reported that self psychology "wishes to minimize the input of the analyst into the mix." It is minimized "to allow a thwarted development to unfold. ... [I]t is based on the idea of a developmental program (one that may be innate or pre-wired if you wish) that will reconstitute itself under certain conditions (p. 387)." This innate or pre-wired developmental program does sound very much like Rogers's actualizing tendency. However, I do agree with Grant that implicit in the tradition of self psychology, and psychoanalysis in general, is the role of the "analyst" as an expert, and this tradition may, in some subtle ways, impact what occurs in the consulting room. I will say more about this role of the "analyst" as an expert later (see p. 107).

Interestingly, some time ago, I spoke, on very separate occasions, to two different senior self psychologists, both women, in New York City. They both lived in Chicago early in their careers and each had an experience of client-centered therapy. Each said the same thing, that they found client-centered therapy superficial. Their experience seems to confirm the experience of Marge Witty (2004), when she noted,

If Barbara T. Brodley had not raised the issue of the distinctions between experiential and client-centered therapy, it is unclear to me whether a genuinely non-directive school of client-centered therapy would have survived ... . At the time I took the practicum at the Chicago Counseling and Psychotherapy Center in 1972, client-centered therapy was taught in a highly oversimplified, shallow way as a kind of active listening. None of the staff at that time transmitted what I now understand to be client-centered therapy (Author Note, p. 22).

Regarding the issue of shallowness in the approach, Brodley (1999) said that over-consistency in the implementation of the

therapeutic attitudes may be detrimental to the relationship (p. 11). This over-consistency may come about

if the therapist is reluctant to address questions or engage in minimal social interactions. The perception also may result from empathic responses that are cognitively accurate but emotionally inadequate. It may be the consequence of a lack in the therapist's spontaneity and therapeutic presence. Consistent but shallow empathic understandings also may stimulate the client's perception of over-consistency. He may perceive the therapist as expressing a false self. (Brodley, 1999, p. 11).

Along with the non-directive attitude, it is important for the therapist to be emotionally present in the relationship (Brodley, 2002, p. 62). Brodley wrote, "A fundamental stance of the client-centered therapist is to act spontaneously (although it is a disciplined spontaneity) and authentically in our relationships with clients" (p. 68). Grant (1990) commented, "a client may request direction, advice, interpretations, or instructions, and the therapist may offer these" (p. 83). He also wrote, "non-directive client-centered therapy is a way of being, and not a method, because it allows the therapist to make novel, personal, unplanned responses" (Grant, 1990, p. 85). And Witty (2004) noted, "the fundamental aim of the client-centered therapist is to offer oneself in an entirely personal way, without professional façade" (p. 30). She added that client-centered therapists

provide an environment for the emergence of a unique therapeutic relationship with each new client and with each client in successive sessions. ... (T)here is a *great deal of variation* in the ways client-centered practitioners interact with their clients—as much variation as there are persons (Witty, 2004, p. 30).

The kind of non-directive therapy described above is an extraordinarily difficult art to learn and practice. To allow one's whole self to participate in the relationship, with a non-directive intent, and, I would like to add, with an awareness of one's own issues, vulnerabilities, and biases, and also a willingness to acknowledge mistakes and errors, seems like a very challenging task for any beginning practitioner. It would be wonderful if in the United States

more training programs could be made available to learn this special skill, which is also an art.

Grant (2010) writes, “In my view, ethics are the heart of all therapeutic practices, and differences among practices should be articulated, defended, and challenged on moral grounds” (p. 38). And for Grant (2004) the non-directive attitude epitomizes this ethical stance. For me, an equally important ethical value in the therapeutic relationship is the openness and honesty of communication, that is, the client-centered attitude of genuineness. In Grant’s review of my article he does not comment on therapeutic genuineness, because he concentrates his focus on non-directivity. Rogers (1985) articulated the importance of this attitude when he was asked what the field of psychotherapy had learned over the past 100 years. He said “I don’t know what the profession has learned, I really don’t. I’ve learned to be more human in the relationship, but I am not sure that that’s the direction the profession is going.”

Sandor Ferenczi (1932/1985), at the dawn of psychoanalysis, epitomized the ethical quality of therapeutic openness, when he courageously experimented with different methods, including “mutual analysis,” in order to help patients recover from trauma. Ferenczi, working by himself, and very much ahead of his time, wanted to maintain an atmosphere of maternal warmth in the therapeutic relationship through the expression of empathy, kindness, compassion, and love (Breger, 2000; Dupont, 1985). He criticized the detached and aloof manner of the mostly male analysts of his era, including Freud, for what he described as their “professional hypocrisy.” He thought an analyst must be “indulgent,” and should not frustrate the patient, an idea that contradicted Freud’s principles of neutrality and abstinence (Breger, 2000, p. 348). To insure an empathic interaction with patients Ferenczi recommended an analyst’s own analysis, right down to “rock bottom” (Rachman, 1989, p. 183, pp. 193-194). Interestingly, mutual analysis reflected a true equality, where analyst and patient reversed roles in different sessions. For different reasons this procedure was not successful, and was abandoned by Ferenczi, but his motivation was to allow for greater honesty and openness in communication. His care and commitment to his patients, his willingness to be expressive, open,

real, and his desire to be self-aware, including of his own faults, continue to be important values of a therapeutic relationship.

One aspect of psychoanalysis that I have incorporated in my therapeutic work is an interest in the relationship between childhood experiences and current behavior and attitudes, which has been variously referred to in the psychoanalytic literature as transferences, organizing principles, or RIGs (representations of interactions that have been generalized). In the 1980s I wrote an article about this issue (Kahn, 1987) in response to John Shlien's (1987) important work at the time, "A Countertheory of Transference." In his paper, Shlien wrote that transference was a fiction. He demonstrated how transference can be used as a defense by analysts "to protect themselves from the consequences of their own behavior" (p. 15). For example, a patient's anger toward an analyst who is detached and neutral is not transference, but an appropriate response to an unfeeling analyst. In agreement with Shlien, I wrote that in an ideal therapeutic moment a therapist understands his or her client completely in a genuine, human interaction. This honest, empathic interaction of the here-and-now is wonderfully therapeutic. However, the transference relationship, which reflects the cause and effect determinism of the natural sciences, is also ever present for both the client as well as the therapist, and should not be ignored. For some clients, a reflective awareness of the past roots of their current issues may be therapeutically helpful. At times, and with some clients, I continue to be interested in understanding the relationship between the past and present, and I may ask a leading question or offer a tentative interpretation regarding these connections. Such an infrequent interpretation or question, when it occurs, is an example, I believe, of empathic understanding. I gave several examples of this phenomenon in my paper (Kahn, 2010, p. 25-26, 28).

I have also experienced on rare occasions clients talking about superficial topics in order to avoid getting to a deeper level or to a more difficult, conflictual topic (see Kahn, 2010, p. 28-29). At these moments I may become a bit bored and I become aware that our communication lacks depth. (I have also experienced this same phenomenon in groups.) Since these are clients that I know well, I may ask a tentative leading question in order to change the direction of

the session to what I believe the client is avoiding. Am I being an expert, am I not respecting the client's self-determination, or is this an example of empathic understanding? Can a client-centered therapist just once in a while be an expert at something other than "not being an expert"? I do like to think that this kind of questioning is an example of empathic understanding, since recently a client, spontaneously thanked me for changing the direction of a session part way through our meeting. For this client, as a result of the change in content, our communication became more alive, real, and interactive.

Such directive intentions by the therapist may be permissible in client-centered practice so long as they are infrequent and not systematic. For example, Brodley (1999) wrote,

Another normal contradiction, infrequent as it is in client-centered work, occurs when the therapist's remarks have a rare momentary directive intention. ... (T)he therapist wants to influence the client toward some particular idea, action or value. ... An occasional, albeit rare, moment of directive intention need not contradict the nondirective attitude as a constant in the relationship if the directivity is not systematic and not frequent (p. 11).

And Brodley (1999) also quoted Raskin as saying,

the client-centered therapist may respond occasionally from her own frame of reference in various ways. Raskin's view is that doing so is an expression of a desirable therapist freedom—that it is valid in client-centered work as long as such communications are not systematic (p. 11).

Different ideas from Kohut's writings on self psychology have contributed to my understanding of clients, and I believe, as a result, enhanced my work as a therapist. For example, the idea that consistent empathic understanding, over time, will help strengthen the structure or cohesiveness of the self is often in the back of my mind. The idea that excessive sex, aggression, gambling, exercise, etc. may be a way of stimulating a depleted, empty and depressed self has also enhanced my empathic understanding of particular clients who have had or continue to have behavioral excesses as their issue. Also my readings of the psychoanalytic literature (e.g. Hoffman, 1998; Bromberg, 1991), including lengthy case reports, has helped me be



more aware, and perhaps more effective as a therapist. In one self psychology case report (Stolorow & Atwood, 1992, p. 114-121) it was shown how a difficulty in the therapeutic relationship was about to cause an angry termination to therapy. This difficulty, however, was resolved as a result of the analyst's own therapy, which he was undergoing at the same time he was seeing his patient. He came to understand that his own vulnerability from a childhood trauma (death of his mother) was interfering with his empathic understanding of the needs of his patient.

Finally, findings from psychoanalytic infant research have illustrated the significance of the attuned relationship between mother and infant, the infant's need for "mirroring," as well as the need for the infant to disengage from the mother, and the importance of the mother's ability to respect this autonomy, will, and disengagement (her non-directive attitude) (Stern, 1985; Goleman, 1986; Beebe & Lachmann, 1992). As a matter of fact, this infant research seems to provide empirical support for the three client-centered attitudes, as well as non-directivity (the mother's ability to allow her infant to disengage and turn away from her). These findings also illustrate the remarkable overlap of core attitudes that are necessary in psychoanalysis, client-centered therapy, as well as in healthy parenting.

There are important differences between relational psychoanalysis and client-centered therapy. The relational analyst feels free to make therapist frame responses, and will not shy away from confrontations. However, Grant (2010) argues "that the practice of client-centered therapy consists fundamentally of the experience and expression of certain attitudes believed to be helpful and respectful of client self-determination (Brodley, 2002; Grant, 2004) and relational therapy does not" (p. 37). I don't think this statement is true. When Bromberg (1991) writes,

the analyst's perception of his patient (his "knowing") is offered to the patient not as a corrective to the patient's faulty or distorted view but as a subjective impression to be explored for its wrongness as well as for its compatibility with the patient's own experience (p. 435),

there does not seem to be a lack of respect for the patient's self-determination. It seems to me, from his quote, that Bromberg's

perception is offered with non-directive intent. Does relational theory give license to some less experienced analysts to respond with unempathic and hurtful confrontations? I imagine it might. But judging from Bromberg's quote there should be no interference with a patient's self-determination in the relational approach.

I do agree with Grant that there are differences between the psychoanalytic and the client-centered approaches, often based on the role of the "analyst" as an expert. Within psychoanalysis a pure and, what is considered, a superior form continues to exist. This approach involves lengthy training for the analysts, and multiple sessions per week and the use of the couch for patients. Aron (interviewed in Safran, 2009), a leading relational analyst, criticized the distinction that is made between this form of psychoanalysis and other kinds of psychotherapy. He said,

as long as we continue to distinguish between psychoanalysis and psychoanalytic therapy, then we have a hierarchy with a privileged elite, so that full-fledged psychoanalysts are somehow thought of as at a higher level than psychotherapists. And that, I think, plays right into a long historical tradition of psychoanalytic elitism, that puts down other kinds of therapists, and that has resulted in real problems (p. 100).

Analysts trained within this orthodox tradition usually prefer seeing patients multiple times per week (Safran, 2009; Stern, 2009; Carrere, 2010), and may urge patients to increase their frequency of visits, which is a form of directivity. On another matter, the holding of "master lecture classes," which are offered at self psychology conferences, clearly diverges from the philosophy and ideals of the client-centered approach. And there is no experience in the psychoanalytic community like the one at the client-centered Warm Springs Workshop, where new students have as much voice and power in the group as more seasoned professionals.

Grant (2010) believes that the client-centered approach, with its non-directive intent, and the three therapeutic attitudes, is morally superior to the psychoanalytic approaches I reviewed (Kahn, 2010). I have cited some of the complexities of the therapeutic interaction in response, and I would want to refrain from judging one approach as being morally superior to the other. Psychoanalysis, with the new and

more humanistic developments in self psychology and the relational approach, and well-trained and well-analyzed practitioners, more often than not, I imagine, live out the client-centered attitudes, including non-directivity, in their work with patients. My personal experience working with a relational analyst tends to confirm this notion.

Finally, regarding the ethics of therapy, I would like to end with an unedited quote by Sandor Ferenczi from his "Clinical Diary" (1933/1985). He wrote,

Should it even occur, as it does occasionally to me, that experiencing another's and my own suffering brings a tear to my eye (and one should not conceal this emotion from the patient), then the tears of doctor and of patient mingle in a sublimated communion, which perhaps finds its analogy only in the mother-child relationship. And this is the healing agent, which, like a kind of glue, binds together permanently the intellectually assembled fragments, surrounding even the personality thus repaired with a new aura of vitality and optimism (p. 65).

I would like to think that in this openness and honesty of communication, in a shared and caring therapeutic relationship, there is a strong similarity between Roger's and Brodley's client-centered therapy and Ferenczi's version of psychoanalysis.

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