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Sándor Ferenczi today in the light of the great psychotherapeutic debate: The forerunner of the theory of common factors and contextual model

Sándor Ferenczi danes v luči velike psihoterapevtske razprave: Predhodnik teorije skupnih dejavnikov in kontekstualnega modela

Abstract

This article discusses Sándor Ferenczi's contributions to psychotherapy in the context of an ongoing debate between two contrasting models: the biomedical model, which emphasises the specificity of diagnosis and treatment, and the contextual/biopsychosocial model, which highlights the similarities between different therapies and healing practices. While Freud failed to move away from the biomedical model, Ferenczi recognized early on the limitations of medical/psychiatric practice based on biological reductionism and laid the foundations for the biopsychosocial approach. There are clear similarities between Freud's original work on hysteria and the biomedical model: a disorder (hysteria); a scientifically based explanation of the disorder (repressed traumatic events); a mechanism of change (insight into the unconscious); and specific therapeutic actions (free association). Despite the tenuous empirical basis of his theory, Freud insisted that psychoanalytic diagnostics and treatment were specific and supported by scientific evidence. Freud's theory is the precursor of all theory-centred styles of psychotherapy. These reached their zenith in the United States during the middle decades of the 20th century. Rather than basing the therapist's superiority on theory, Ferenczi emphasised curious enquiry in clinical practice, reflecting on it and continuously revising it. This stance aligns with contemporary practice-based research grounded in the contextual model.

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Consequently, this article provides a thorough overview of Ferenczi's pioneering contributions within the framework of the theory of common factors and the contextual model. These contributions encompass original insights into client and therapist factors, therapeutic alliance, feedback, and the impact of technique.

Key words: Ferenczi, Freud, biomedical model, biopsychosocial model, contextual model, common factors, theory-centred psychotherapy, psychology of two, intersubjectivism, placebo

Povzetek

Članek prikazuje prispevek Sándorja Ferenczija k razvoju psihoterapije z vidika velike psihoterapevtske razprave, ki poteka že več kot 150 let med dvema modeloma psihoterapije – med biomedicinskim, ki temelji na specifičnosti diagnostike in obravnave, ter kontekstualnim/biopsihosocialnim modelom, ki poudarja skupne značilnost različnih terapij in zdraviteljskih praks. Medtem ko se Freudu ni uspelo oddaljiti od biomedicinskega modela, je Ferenczi zgodaj prepoznal omejenost medicinske/psihiatrične prakse, temelječe na biološkem redukcionizmu, in položil temelje biopsihosocialnega pristopa. Npr. Freudova konceptualizacija histerije se sklada z biomedicinskim modelom, saj jo je definiriral kot specifično duševno motnjo, ki naj bi imela znanstveno utemeljeno razlago etiologije (potlačeni travmatični dogodki) in mehanizma spremembe (uvid v nezavedno), iz tega pa naj bi izhajal specifični terapevtski ukrep (prosto asociiranje). Kljub šibki empirični podlagi je Freud vztrajal, da sta psihoanalitična diagnostika in obravnava specifični in podprti z znanstvenimi dokazi. Tako je Freudova psihoanalitična teorija postala predhodnica vseh teoretično usmerjenih stilov psihoterapije, ki so dosegli svoj razcvet v Združenih državah Amerike sredi 20. stoletja. Za razliko od Freuda pa je Ferenczi poudarjal rado vedno raziskovanje, reflektiranje in nenehno revidiranje klinične prakse, kar se sklada s sodobnim raziskovanjem psihoterapije, utemeljenim na praksi in kontekstualnem/biopsihosocialnem modelu. Zato se članek zaključí s temeljitim pregledom Ferenczijevega pionirskih prispevkov k razvoju teorije skupnih dejavnikov in kontekstualnega modela. Ti prispevki vključujejo izvirna spoznanja o dejavnikih klienta in terapevta, terapevtski aliansi, povratnem informiranju in vplivu tehnik.

Ključne besede: Ferenczi, Freud, biomedicinski model, biopsihosocialni model, kontekstualni model, skupni dejavniki, teoretično usmerjena psihoterapija, psihologija dveh, intersubjektivizem, placebo

1.

Introduction

The work of Sándor Ferenczi (1873-1933) has stood the test of time, and we can still discover how innovative his work was from the new perspectives offered by the development of psychotherapeutic science and clinical practice. As the Slovenian saying goes - he was a cock crowing too early. And such roosters are never popular. Misunderstood and often even hated by their environment, they often (mis)doubt themselves and even die unhappy. Only time, which is longer than a human life span, measures the quality of their work and their contribution to the community.

The perspective from which I will evaluate Ferenczi's oeuvre is the "great psychotherapeutic debate", which today is one of the central professional and scientific points of the development of psychotherapy. It is through this debate that psychotherapy is increasingly establishing itself as an independent profession and as an autonomous scientific discipline that offers better solutions in the field of mental health care within the framework of a biopsychosocial approach than the biomedical approach, whose harmful effects are becoming more and more alarming due to the over-medicalisation of mental health (e.g. Davies, 2021; Deacon, 2013; Flaker, 2023; Freitas & de Azevedo, 2022; Götzsche, 2015; Healy, 1990, 1996, 1997, 2006, 2008, 2012; Johnstone, 2022; Lamovec, 1995; Lebowitz & Appelbaum, 2020; Makovec, 2019, 2020; Mallett & Runswick-Cole, 2016; Miškulin, 2016, 2017; Moncrieff, 2018; Moynihan & Cassels, 2005; Možina, 2021b, 2024ab; Olfson & Marcus, 2010; Runswick-Cole et al., 2016; Seikkula & Arnkil, 2024; Slatnar, 2012; Sturmberg, 2015; Šugman Bohinc & Miškulin, 2024; Timimi, 2021, 2025; Timimi & Leo, 2009; Timmermans & Berg, 2003; Ule, 2009, 2012; Verhaeghe, 2008, 2014; Wampold et al., 2001; Watters, 2010; Whitaker, 2004, 2010; White, 2002).

Ferenczi was among those who recognised early the narrowness of medical/psychiatric practice based on biological reductionism and built the foundations of a biopsychosocial approach. Because he was so far ahead of his time, it is only from today's stage of development of psychotherapy and other mental health sciences that it is possible to correctly assess how remarkable his contribution is, especially if we take into account how his ideas and discoveries have been further developed by his many students of the so-called 'Budapest School of Psychoanalysis' (e.g. Michael Balint, Melanie Klein, Clara Thompson, Therese Benedek, etc.) (Bohak, 2022; Haynal, 2011). Rather than shifting towards transdiagnostics and strengthening psychosocial forms of support in the context of holistic treatment, the field of mental healthcare continues to use categorical psychiatric diagnoses and the use of psychopharmaceuticals is increasing

exponentially. In this context, Ferenczi's contribution to the development of psychiatry, psychosomatic medicine and psychotherapy remains highly relevant. He was well aware of the conditions that contribute to effective psychotherapy, which are now known as 'common factors' and are included in the contextual model of psychotherapy.

2. 150 years of the great psychotherapy debate between medical and contextual model

In the first edition of the book 'The Great Psychotherapy Debate' (Wampold, 2001b), and its second expanded edition 14 years later (Wampold & Imel, 2015), Bruce Wampold presented two competing models of psychotherapy – the 'medical model', which advocates the specificity of treatments, and the 'contextual model', which emphasizes the commonalities among different therapies and healing practices. He questioned the long-held belief that psychotherapy is best understood through the medical model. Through a balanced and careful selection of research, he proposed the contextual model as the better alternative to the medical model. He criticized the excessive emphasis on empirically supported methods of psychotherapy based on the medical model and called for the continuation of common factors research, from which the contextual model grew in the 1960s (Frank, 1961, 1971; Frank & Frank, 1991; Možina, 2020, 2021ab; Wampold, 2010ab).

In his historical overview of 150 years of the great psychotherapy debate, Wampold outlined (mainly focusing on a historical account of psychotherapy development in the United States) the key developmental currents of medical and contextual models. The first, which dominated and still dominates the scientific discourse on psychotherapy, is linked to the development of modern medicine from the middle of the 19th century onwards. The other, which is more intertwined with broader cultural currents, traditional healing practices and humanism (Wampold, 2001a, 2012) and which the common factors theory and the contextual model are part of, remains in the background despite its long tradition and the fact that it could serve as a core and key source for the development of modern psychotherapy science and clinical practice.

In the following, I will show how Freud intended to move away from the biomedical approach, but ultimately did not. Ferenczi, on the other hand, dared to take that step — and paid a heavy price for it.

3. The medical model and Freud's conception of psychoanalysis

Along with materialistic etiology, the medical model developed its corollary, specificity, which

"refers to the manner in which treatments render their effects. A treatment is said to be specific treatment if the components of the treatment address illness by altering those physiochemical aspects of the body that were responsible for the illness. Generally, specificity in medicine relies on demonstrable alterations of the physiochemical process responsible for the disease and either a removal of the disease (i.e. cure) or a reduction in the severity of the disorder above what could be obtained through effects created by the mind by such factors as hope, expectation and conditioning." (Wampold & Imel, 2015, p. 4)

The specificity of the treatment therefore follows the specific diagnosis made beforehand. Without this, specific treatment is not possible.

Wampold outlined five key assumptions or components of the medical model, which also had a decisive influence on the mainstream of the development of psychotherapy: illness or disease, biological explanation and biological mechanism of change, therapeutic procedures and specificity:

"First, there is a disorder, problem, or complaint (e.g., the client is suffering from intrusive thoughts, distractibility, and depression).

Second, there is an explanation for the problems; in medicine the explanation would be biological (e.g. the patient's stomach pain was an ulcer caused by bacteria), whereas in psychotherapy the explanation would be psychological (e.g. the patient's insomnia is the result of traumatic experiences).

Third, there exist mechanisms of change that are consistent with the theoretical explanation for the disorder (e.g. extinction).

Fourth, the mechanisms of change suggest that particular therapeutic actions should be used (e.g. prolonged exposure).

Fifth, and most important, the therapeutic action is responsible for the benefits of the psychotherapy and not other factors, such as the alliance with the therapist (i.e. the decrease in symptoms was caused by prolonged exposure and not other therapeutic actions or conditions)." (Wampold, 2010a, p. 51)

The last component, the specificity of methods or techniques, is the most important one according to the medical model and gives priority or primacy to specific therapeutic factors over common, contextual factors.

Considering that medical science in the second half of the 19th century was exclusively biophysiologicaly oriented, so that only priests, philosophers and artists were concerned with understanding human mental distress and suffering, we can appreciate Freud's courage in focusing on the study of mental processes and conversational forms of help all the more. It is even more admirable that he was opposed to psychoanalysis passing into the hands of doctors, but rather wanted to place it in the hands of a new profession. For doctors who wanted to practise psychoanalysis, however, he gradually introduced the same conditions as everyone else - knowledge of the theory, supervised practice and self-study analysis (Freud, 1999). At the same time, he was constantly striving to ensure that psychoanalysis would not be labelled as quackery by official medicine, but would be recognised as a scientific discipline. He therefore devoted himself first and foremost to the construction of a complex theory, which he was increasingly convinced was scientific. In laying the theoretical foundations of psychoanalysis, he unfortunately remained faithful to the medical model.

The similarities of Freud's original work on hysteria with the medical model are apparent: a disorder (hysteria), a scientifically based explanation of the disorder (repressed traumatic events), a mechanism of change (insight into the unconscious), and specific therapeutic actions (free association) (Freud & Breuer, 2004). Freud insisted that his theory was correct and that psychoanalytic treatment was specific and supported by scientific evidence, even though the empirical base was tenuous (Wampold & Imel, 2015, p. 18).

The rapid spread of psychoanalysis in the USA is testimony to the fact that even the fruits of Freud's mature period of developing psychoanalytic theory remained within the medical model. Within a few years of Freud's only visit to the USA and his lectures at Clark University in 1909, psychoanalysis became the main psychotherapeutic approach there, practised almost exclusively by doctors. Freud was very critical of the American experience and was not eager to visit again or to participate. The author of a biography of Freud, Ernest Jones, reports that he even declared America to be a 'gigantic mistake' (Jones, 1975). Nor did he expect his ideas to fall on such fertile ground there. How is it possible, then, that the medical profession embraced it with such open arms?

On the one hand, because scientific developments in psychiatry were still in their infancy and, as a result, doctors did not have convincing evidence of organic causes of mental illness that the general public could believe (unfortunately they still don't have it, but the difference is that the general public believes they do have the evidence). Psychoanalytic theory, which could be fitted into the medical model, came in very handy, as the unexplained organic causality was replaced by psychological causality. And although such an aetiology was not

scientifically validated, it was both promising and convincing enough for both patients and the general public. Psychoanalysis made doctors more competitive with various forms of conversational forms of help not provided by doctors (e.g. psychologists and spiritual healers).

Namely, in the late 19th and at the beginning of the 20th century, in the USA (a similar thing also happened in Europe), 'moral therapy' was a strong competitor to psychiatry (Cockerham, 2017). Despite the fact that psychoanalysis was more myth than science, by the 1950s doctors were able to successfully present Freud's complex theory as more professional or even scientific than various religious forms of help for mental health problems (e.g. in movements such as Christian Science and the New Thought Movement), and to establish a new fashion trend for an upper-class clientele.

Moreover, admittance to psychoanalytic institutes and the practice of psychoanalysis was largely limited to physicians, further defining psychotherapy as a medical practice². Until the mid-century the roles were clear: "The division of labour by discipline was unquestioned: Psychologists did intelligence testing and assessment of personality, usually the Rorschach test; social workers did the interviewing; and psychiatrists conducted therapy" (Frank, 1992, p. 392). From this period, the impression remained that psychotherapy must be performed by physicians. It was not until the late 1950's that the exclusivity of physicians decreased and psychologists began to practice psychotherapy more prevalently³. Nevertheless, even in the second half of the 20th century, the impression persisted (and in some places still persists, Slovenia being a prime example) that psychotherapy should be carried out primarily by psychiatrists or only by those working under their supervision in the health service.

However, psychoanalysis began to be increasingly criticized by behaviourists who offered new therapeutic techniques (e.g. systematic desensitization

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- 2 Freud also trained analysts who were not physicians, for example Theodore Reik, who was charged with the crime of practicing medicine without a license. Although Reik was acquitted, upon Freud's death, access to the psychoanalytic institutes for non-physicians, including psychologists, was further restricted (VandenBos et al., 1992).
 - 3 Bentall (2009) links the birth of clinical psychology to the lack of doctors willing to work in the post-war psychiatric hospital system. The first formal study of clinical psychology in England was thus introduced in 1948 by Aubrey Lewis, a British professor of psychiatry, who saw the main function of clinical psychologists as being to make clinical psychological diagnoses for psychiatrists. Bentall compares this expectation of psychiatry to the relationship between doctors of other specialties and laboratory technicians who provide doctors with the results of biochemical laboratory tests. Over time, clinical psychologists of the time became frustrated by such expectations and began to develop new forms of psychological therapies. The 1950s and 1960s were a time of the development of behaviour therapy, the precursor of cognitive behaviour therapy, and also a time when an alternative to behavioural engineering was born in psychology. It was the humanistic approach of psychologist Carl Rogers (1942ab, 1951ab, 1957, 1961) that brought awareness of the importance of the therapeutic relationship to psychology and other helping professions. Bentall believes that this period also saw the birth of the ambivalent relationship between psychiatry and clinical psychology, which he believes, to this day, should not be spoken about out loud.

(Wolpe, 1958)) based on experimental learning theory and empirical psychology (Eysenck, 1959, 1961, 1966). Despite claims that their approach differed from the medical model (they claimed, for example, that mental disorders were the result of learning based on interactions with the environment, rather than biology), systematic desensitization, such as psychoanalytic treatment, had many structural similarities to the medical model:

“It is used to treat a disorder (phobic anxiety), is based on an explanation for the disorder (classical conditioning), imbeds the mechanism of change within the explanation (desensitization), and stipulates the therapeutic action necessary to effect the change (systematic desensitization). So, although the psychoanalytic paradigm is saturated with mentalistic constructs whereas the behavioural paradigm generally eschews intervening mentalistic explanations, they are both systems that explain maladaptive behaviour and offer therapeutic protocols for reducing distress and promoting more adaptive functioning.” (Wampold & Imel, 2015, p. 20)

Thus the starting point for both behaviourists and psychoanalysts was psychopathology:

1. The diagnosis of the patient was made in accordance with the psychopathology.
2. Treatment followed accordingly to ameliorate or cure the psychopathology.
3. The psychotherapy theory was derived from the psychopathology.
4. The psychopathology was found and was factual and the theory was developed from it. (Barnes, 2002b, str. 12).

Barnes called such an approach ‘theory-centred psychotherapy’ (ibid.) based on Toulmin’s concept of ‘theory-centred styles of philosophy’. Toulmin has revised the narrative of the 17th-century philosophical commitment to rationalism. This was when philosophers shifted their focus to written, universal, general and timeless theories. According to Toulmin’s account, they underwent a “change of attitude” that devalued “the oral, the particular, the local, the timely, and the concrete”. This change appeared to them “a small price to pay for a formally ‘rational’ theory grounded in abstract, universal, timeless concepts” (Toulmin 1990, p. 75). Barne pointed out:

“Theory-centred styles of psychotherapy state problems and seek solutions in timeless, universal terms, replacing the concrete with the abstract and blurring the present with a reconstructed past. There seems to be a belief that practice can operate separately from theory within theory-centred psychotherapy. I claim that in theory-centred styles of psychotherapy the theory becomes inseparable from practice.” (Barnes, 2002b, str. 21).

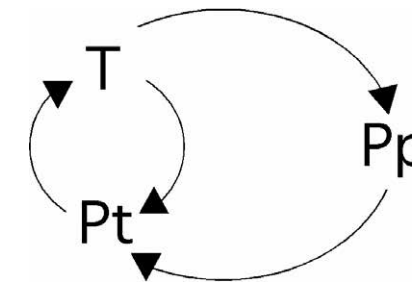
So, we can add to Wampold’s five components of the medical model a sixth: the medical model is theory-centred. Each psychotherapy approach, which is

theory-centred like the medical approach, proposes psychopathology and then plants the psychopathology on clients. The problem with such an approach is that

“psychopathology is not found (i.e. a given) but rather is derived within the context of psychotherapy, through the application of theory. The relationship between psychopathology and the theory of psychotherapy is circular, in strict contrast to the linear dependence of the received view. Thus, theory (T) creates psychotherapy (Pt) just as psychotherapy makes theory; psychotherapy-theory (Pt – T) brings forth psychopathology (Pp) just as psychopathology gives rise to psychotherapy-theory (Pt – T)” (ibid., p. 13) (Figure 1).

Figure 1

The circular relationships between theory, psychotherapy-theory and psychopathology (Barnes, 2002a, p. 13)



Psychotherapy therefore proposes psychopathology and applies it as defined in the logic of the theory. Every psychopathology is a logical consequence of theory and at the same time represents an explanation of the logic of that theory. Theory changes theorists and psychotherapists as well as clients. When we place psychopathology in clients or attribute psychopathology to them, theory changes them into its subjects.

The pragmatic value or usefulness of theory lies in the fact that it creates patterns and thus contributes to simplification, to reducing the complexity that we constantly encounter in therapeutic work and in life in general. Without reducing complexity, it would often be difficult to orient ourselves, make decisions, and reach pragmatic compromises for effective action in line with our intentions. However, when we use psychopathological categories in therapeutic work for orientation and assistance in deciding how to proceed, we should not forget that they are based on a theory that can never fully capture the rich diversity of our clients’ experiences and behaviours. One of the consequences of theories always being like Procrustes’ bed is that there is a constant need to expand existing theories, i.e., to add complexity, which can make the theory (and consequently also psychopathology) less and less attractive, since its basic

purpose is simplification. This is exactly what has happened in recent decades with the American psychiatric classification, which has seen a sharp increase in the number of mental disorders: there were 180 in the second edition of the DSM, 292 in the third, 365 in the fourth, and as many as around 500 in the latest, DSM-V version (Verhaeghe, 2008, 2014).

Freud was very clear in his justifications of psychoanalysis as a theory-centred approach. His theory is the precursor of all theory-centred styles of psychotherapy. He started his psychotherapy career in the context of hypnosis, where healing occurred solely through communication without relying on grand theory (Ellenberger, 1970; Erickson, 1980; Gauld, 1992). Based on the discoveries he made in his clinical practice with hysterical patients and later by abandoning hypnosis, he was able to formulate a theory of repression, which became the cornerstone of psychoanalysis. He claimed that the theory of repression and resistance is one of the 'findings' and not among the 'premises' of psychoanalysis. In his 'Introductory Lectures on Psychoanalysis' he wrote that psychoanalysis originated as an "arduous and exacting" method of treatment and that it "possesses a doctor either entirely or not at all," admitting that "as a method of treatment it is one among many, though, to be sure, *primus inter pares*" (Freud, 1964, p. 157).

In lecture 24 he also wrote that "the theory of the neurosis is psychoanalysis itself" (Freud, 2013, p. 332) and in lecture 1 he explained how theory-centred psychotherapy guides the psychotherapist:

"The patient talks, tells of his past experiences and present impressions, complains, confesses to his wishes and his emotion. The physician listens, tries to direct the thought processes of the patient, exhorts, reminds him of things, forces his attention into certain channels, gives him explanations and observes the reactions of understanding or denial which he calls forth in the patient." (ibid., p. 11)

In classical psychoanalysis, the basis for all therapist's directions, explanations and observations is Freud's theory: "Freud habitually insisted that theory and therapy are really the same" (Rieff, 1961, p. 113). Barnes (2002b) commented:

"It seems that for Freud (as his letters to Arnold Zweig show) to fulfil his destiny as a psychoanalyst and to live his life as a theorist were identical. How he talked about patients (and people in general) was progressively shaped by his theory. His theory also enabled him to understand the aversive attitude of his contemporaries toward him – to understand their rejection of his theory – and 'to see it as a necessary consequence of fundamental analytic premises,' as he framed it in his essay on the history of his movement. Eventually, he seemed only to talk about what he was doing, and to frame what others were

doing, within the terms set by his theory" (ibid., p. 6).

Freud's inner circle of followers also continued to conflate theory and psychotherapy, drawing their metaphors and analogies from the mechanisms of late 19th-century science. They were followed by the neo-Freudians, and later by other therapists who often did not question the assumptions that underpinned their thinking, feeling and acting. Even today, most psychotherapists think that they are using theories, but they are ignorant of the effects these theories have on them (Možina & Barnes, 2020ab).

These theory-centred styles of psychotherapy, and their appeal to popular culture, reached their zenith in the United States during the middle decades of the twentieth century (Hale, 1995), and theory-centred efforts in clinical practice and psychotherapy research persist to this day:

"Indeed, acceptance of common factors as the cause of the benefits of psychotherapy would collapse the entire scaffolding of the theoretical bases of modern psychotherapy as conceptualized by the field and presented to the public. Consequently, the field of psychotherapy has attempted to establish the primacy of treatment and has attempted, through the use of placebo-type control groups and other designs, to rule out common factors as the critical component explaining the benefits of psychotherapy" (Wampold & Imel, 2015, pp. 33-34).

The predominant habit of theory-centred psychotherapists (and scientists in general) is to simplify problems by ignoring the possibility that the larger context may influence the smaller. Most of them think they are using theories, but are unaware of the effects that these theories have on themselves. They do not take into account that we do not think theories, but theories think us (Bateson, 1972/1987). They do not sufficiently explore the larger context, the historical and socio-political background that has brought about the theory that is being used by them to solve (or, unfortunately, also aggravate) particular social and ecological problems (Barnes & Možina, 2020).

4.

Differences between Freud's and Ferenczi's approach to psychotherapy

With his constant searching for innovations, most of which were introduced between 1920 and 1933, Ferenczi was very provocative for Freud's theory-centred approach. This is why Freud's loyal circle of followers called him the 'enfant terrible of psychoanalysis' (Ferenczi, 2020; Pap, 2020). From today's perspective it is clear that many of Ferenczi's ideas and innovations in clinical work were paving the way for the inclusion of those principles and elements that today

are known as common factors and are the basis of the contextual model. Freud was not ready to accept the corrections of his theory-centred approach although Ferenczi’s contribution to the development of psychoanalysis in its early period was crucial. As it would be detrimental for physicians’ faith in the medical model to say that medications are potent because of the placebo effect, which would mean attributing potency to common factors, it is understandable that Freud resisted the innovations which pointed at the importance of common factors, because the whole edifice of his theory would collapse. From the perspective of the great psychotherapeutic debate, the tragic end of their collaboration is therefore easier to understand. The fundamental differences in how they understood the key assumptions of psychotherapy, the first within a biomedical approach and the second within a biopsychosocial/contextual approach, were too great (Table 1).

The psychoanalytic movement responded to their disagreement with evasion and silence, followed by various fictitious statements about the two men. According to Balint (1969/1992), Ferenczi was unable to accept Freud’s well-intentioned and well-founded criticisms due to his own insecurities, and instead saw in them only a lack of understanding. He believes that their characters had many common roots, which at first acted as a strong attraction, then served for many years as the basis of a genuine and happy friendship, and eventually led to a tragic end when they both, as the entire psychoanalytic community, experienced loss. Although personal characteristics certainly contributed to the tragic story of their relationship, from today’s perspective we can conclude that their different professional orientations towards the medical or contextual model played an important, perhaps even crucial part in their divergence.

Table 1
Differences between Freud’s and Ferenczi’s approach to psychotherapy.

FREUD biomedical approach	FERENCZI biopsychosocial/contextual approach
objectivist epistemology	circular epistemology
the linear model: mental disorders have their origin in the psyche	the circular model: the origin of mental disorders and physical illnesses lies in the circular relationship between the soma and the psyche (psychosomatics)
theory takes precedence over practice	practice takes precedence over theory, theory must be revised in the light of clinical practice

FREUD biomedical approach	FERENCZI biopsychosocial/contextual approach
clinical practice must confirm theory	the therapist must adapt the methods and techniques to the patient's needs
psychology of one, one-sided analysis	psychology of two, mutual process instead of one-sided analysis
exclusion of the observer from the field of observation; emphasis on content	participant observation; emphasis on process
the therapist is an objective observer of the client's psychic events, which must not be influenced by the therapist's subjectivity (abstinence rule)	the therapist tries to create the conditions for the client to have the experience of a 'good enough' mother; the important relationship is here and now (abstinence is impossible)
objectivism: the therapist can reflect and interpret the patient on the basis of his own theory	relativism: therapist self-reflexivity - therapist monitors the impact of own theoretical assumptions and techniques on the client's experience and therapeutic process, taking into account client's feedback
the therapist is the one who analyses and knows, on the basis of psychoanalytic theory, what the patient's problem is and what the solution is	the client's subjectivity is equivalent to the therapist's subjectivity; as the therapist can analyse the client, so the client can analyse the therapist (mutual analysis)
transference is the transfer of past repressed contents into new relationships;	transference is the realisation of object relations in the relationship with the therapist;
countertransference is the therapist's response to the client's childhood content; it is a disturbing factor that the therapist must control	countertransference is an inevitable part of the therapeutic process and can be used by the therapist for therapeutic purposes
specificity: based on a specific diagnosis derived from the theory of neuroses, a specific therapeutic procedure follows (free association)	contextuality: the effect of the techniques depends on the therapeutic context, which is co-created by the therapist and the patient on the basis of the therapeutic alliance
the aim of the exploration is the client's isolated psychic apparatus	the aim of the exploration are old and new (corrective) relational experiences

Szecsödy (2007, p. 39) summarized well the main characteristics of Ferenczi’s innovative contribution, which clearly point in the direction of common factors and contextual/biopsychosocial approach:

- the creation of an intense emotional atmosphere is important for reliving childhood traumas,
- counter-transference analysis is central for the process,
- mutual participation is essential for the authenticity of interaction,

- empathy is fundamental for the maintenance of the subjective experience of the analysands,
- to experiment clinically is more essential than upholding doctrinaire knowledge,
- the highest goal of psychoanalysis is to heal – by means of the warm and responsive approach of the analyst,
- the analyst has to have an experience of a deep personal analysis,
- the analyst shall maintain a continuous self-analysis and peer supervision.

Ferenczi introduced the idea that the therapist must adapt the method to the client's needs and not the opposite. This idea returns in Winnicott's concept of 'holding' and in Kohut's self-psychological approach (Bohak, 2022). Ferenczi was passionately interested in the problems associated with the use of psychoanalytic techniques. He believed that it is not the task of the psychoanalyst to select clients who could benefit from his techniques, but that the psychoanalyst must adapt the psychoanalytic method and techniques to each individual client. As long as the client wants to continue therapy, it is the therapist's duty to find techniques or individualized approach to help him. The therapist has to invent something new for every client, which is today one of the central principles of common factors theory.

While for Freud, within his objectivist epistemology, the question of what is real and what is fantasy in the therapeutic relationship was important, from the perspective of Ferenczi's relational, circular epistemology, what was more important is the negotiation of (dis)agreement or the exploration of the different perspectives of the client and the therapist, including what is real and what is fantasy for whom, and according to what criteria. Real and fantasy became just two possible ways of emphasising what the therapist and the client can do to convince the other more or less.

Freud tried to convince himself and others that he was the one who knew (better than the client) and could control the client on the basis of the great structure of psychoanalytic theory. Ferenczi, on the other hand, as a pioneer of the psychology of the two, took into account his own autonomy and that of the client, as well as the autonomy of the therapist-client dyad. The therapist, who according to Freud is supposed to impartially and objectively interpret the therapeutic process, was for Ferenczi only part of the reciprocal process of the therapeutic dyad and its contents. More important for Ferenczi was the exploration of the therapeutic process than the description and exploration of the conscious and unconscious contents in the client and the therapist. Ferenczi was the first to stress that psychoanalysis should be understood as a process. Therapist and client participate in a mutual therapeutic process as companions in an unpredictable adventure.

Instead of building the therapist's superiority on the basis of theory, Ferenczi emphasised the curious inquiry in clinical practice, including the inevitability of mistakes, which must be reflected upon and continuously revised. Ferenczi also set a course of development that gradually led to the abandonment of discussions about the therapist's abstinence and involvement, so that the therapist's 'abstinence' became merely one way of co-creating the relationship, and could only be effective in certain circumstances, but could also be harmful (e.g. when working with more difficult pathologies).

Ferenczi's ideas also contributed to the development of psychosomatic medicine (and thus to the development of the biopsychosocial approach), both theoretically and clinically. He wanted to make general practitioners aware of the contributions of psychoanalysis in the prophylaxis for neuroses and the awareness of the psycho-genesis of certain somatic illnesses. He also suggested that sanatorium teams caring for patients with pulmonary diseases should always include a psychoanalyst, which in 1923 was a revolutionary proposal (Oppenheim-Gluckman, 2015, p. 17). In the text published just before his death he stressed the contributions of psychoanalysis to medicine in terms of enabling unconscious psychic factors to be taken into account in illnesses, and the treatment of the patient along with the illness (Ferenczi, 2002).

In an article entitled 'Brief presentation of psychoanalysis', published after his death (Ferenczi, 1982), he returned to the theme of 'psychoanalysis to serve the general practitioner'. A component of any medical treatment is the way in which the doctor 'prescribes himself'. However, he adds, "the Faculty does not tell us how to dose this medication, nor what are its modes of action" (Ferenczi, 1982, p. 150), while psychoanalysis provides precise knowledge and well-defined methods in relation to this question. These ideas were the basis for Balint's book 'The Doctor, His Patient and the Illness' (Balint, 1957/2000) and his work in the Balint Groups (Balint & Norell, 1973). Balint linked medication and 'how the doctor prescribes himself' to the primitive object relation and to the domain of the 'basic fault' (Balint, 1969/1992). This laid the foundations for the attachment theory later developed by John Bowlby (1998).

5.

Differences between Freud and Ferenczi in relation to theory

Ferenczi was impressed by Freud's genius and at first tried to remain fundamentally faithful to his theory. Many of Ferenczi's works leave the impression of a 'mitigating quality'. He often begins them with a note such as the following: "What I want to say may seem new and radical to many, but it is just an old

Freudian idea, mildly analyzed at this point" (Ferenczi in Kulenović, 1989, p. 184). Such and similar remarks became more and more frequent over time, as he himself began to become more and more aware of the difference between Freud's and his ideas, and has never been able to give up the right to independent thinking (Korpar, 2013). He was constantly searching and never wanted to create a grand theory, as Freud did.

Mészáros (2014) also pointed out the difference between Freund and Ferenczi regarding their stance towards theory:

"Ferenczi's primary aim was to heal patients. He readily diverged from theory if it was unfruitful during therapy. This was the opposite of Freud's attitude. When curing patients, Freud always placed theoretical considerations first. He was not interested in healing itself; for him, practising psychoanalysis provided for his living expenses and represented an unlimited source for developing theory." (p. 18)

He was more interested in the treatment itself and never the working out of a tidy system (Balint, 1967). His work did not fit into any preconceived frame:

"He always regarded himself as belonging to the younger generation of research workers; justly, for his whole scientific work is one continual impetus without any trace of the flagging of age. His active mind was always ready to forget every conclusion however respectable and to regard anew, naively, wonderingly, phenomena seen a thousand times. He could not bear empty formulas and pompous pretentious learnedness; on the contrary, he prized above all concrete clinical observations and a thorough examination of the condition of the patient. The academicians of our science did not like him, they feared his élan and regarded him as an enfant terrible. Ferenczi took note of this nickname with a bitter smile; it hurt him, but also made him feel proud." (Balint, 1957/2000, p. 241)

Ferenczi, in his critical attitude towards theory-centred psychotherapy, stressed that psychoanalysis must be based on the reliving of repressed contents in the relationship between the patient and the analyst, not on theoretical explanations of the patient's problems, and that the metapsychology of psychoanalysis must be continually updated in line with new insights from practice, rather than the understanding of the patient's problems conforming to previously created theories (Pap, 2020). Today, contemporary practice-based research based on the contextual model is striving in the same direction (Barkham & Margison, 2007; Green & Latchford, 2012; Margison et al., 2000).

Ferenczi's approach to theory was significantly influenced by his friend, Otto Rank (1884–1939). Like Ferenczi, Rank was a loyal collaborator and friend of Freud's, but also an independent thinker (Bohak, 2022). In 1924, Ferenczi and Rank published the book 'The Development Goals of Psychoanalysis'

('Entwicklungsziele der Psychoanalyse') (Ferenczi & Rank, 1924). Both insisted that theory should always be grounded in clinical practice and not the other way around. They warned of the dangers of trying to fit clients into the boxes of psychoanalytic theory instead of listening to them, and of attributing to them problems or failures for which the psychoanalyst is responsible (Dupont, 2023). They criticized psychoanalysts' 'interpretive fanaticism' arising from a theory-centred approach, and emphasized the importance of the patient's re-experiencing and resolving his unconscious conflicts in the transference. In other words, they gave greater importance to the therapeutic relationship as a common factor rather than to the therapist's interpretations derived from psychoanalytic theory.

They also stressed that the task of the psychoanalyst is to transform, step by step, a pathogenic conflict into an acceptable and tolerable one. In this, psychoanalysis is not a simple intellectualisation, but a unique, corrective emotional experience that helps the patient to make profound changes.

They also highlighted techniques that made it possible to shorten the therapy and thereby make it available to a larger number of people. In addition, they listed some mistakes that should be avoided and emphasized that the task of the psychoanalyst is to transform the pathogenic conflict step by step into an acceptable and tolerable one. Here, psychoanalysis turns out to be a unique emotional experience that helps the patient to have a deep conviction instead of just simple intellectualization. The book was met with a poor response within the psychoanalytic community; Ernest Jones even assessed it as disastrous. The authors were criticized for not consulting the secret psychoanalytic committee before publication. Freud was also not satisfied with the contents of the book because he feared that it would dilute psychoanalytic theory (Bohak, 2022).

Shortly after the publication of this book, Rank published another one entitled 'The trauma of birth' (Rank, 1924). The psychoanalytic community was shocked. Freud initially accepted the book in part, but later rejected it. Outrage erupted among English and German psychoanalysts, with Ernest Jones and Karl Abraham as leaders. Otto Rank was the first to point to the central place of mother in human development and insisted that the Oedipus complex is not the cause of every neurosis, but that many critical events and situations occur in the pre-Oedipal period. He even claimed that birth itself is a trauma that leaves traces.

Although Freud acknowledged the existence of this trauma, he understood it in a strictly biological sense. For Rank, the essential point was the separation from the mother and the security that the mother represents. This idea threatened the centrality of the Oedipus complex, a basic concept in Freud's theory. Rank tried, unsuccessfully, to convince Freud that many essential things can

happen before the Oedipus complex is even activated. After being encouraged to do so by one of his students, Freud finally completely rejected Rank's theory, and soon after, Rank himself. Like Ferenczi later on, he was characterized as deviant and mentally unstable.

However, as in the case of Ferenczi, the psychoanalytic community has grossly exaggerated the role of this break. Despite the break, Freud tried to maintain certain ties with Rank whenever possible, and maintained his friendship with Ferenczi despite the disputes. Thus, Rank and Ferenczi were excluded from the psychoanalytic community for several decades, and as a result the vast majority of psychoanalysts ignored their writings.

Initially, Ferenczi tried to defend Rank. However, unable to bear Freud's possible disapproval, he eventually rejected Rank and his ideas, which were very similar to his own. After that, it became increasingly clear that Ferenczi was following his own path. He was no more successful than Rank in presenting his original ideas, and he also failed to get them accepted by others. One of his works, however, was an exception to this rule. It was *Thalassa* (Ferenczi, 1989). Freud saw this work as Ferenczi's greatest achievement.

6. Ferenczi as a forerunner of the theory of common factors and contextual model

Pap (2020) sees the main feature of Ferenczi's experimental practice from 1920 to 1933 as the modernisation of psychoanalytic technique. Bohak (2022), in line with Benedek (1993), also stresses that he was above all a recognized master of psychoanalytic technique. However, in his 'Clinical Diary' (Ferenczi, 1988), Ferenczi himself describes how he put a genuine personal relationship with the patient far ahead of technique, which he was even willing to abandon at the expense of empathy:

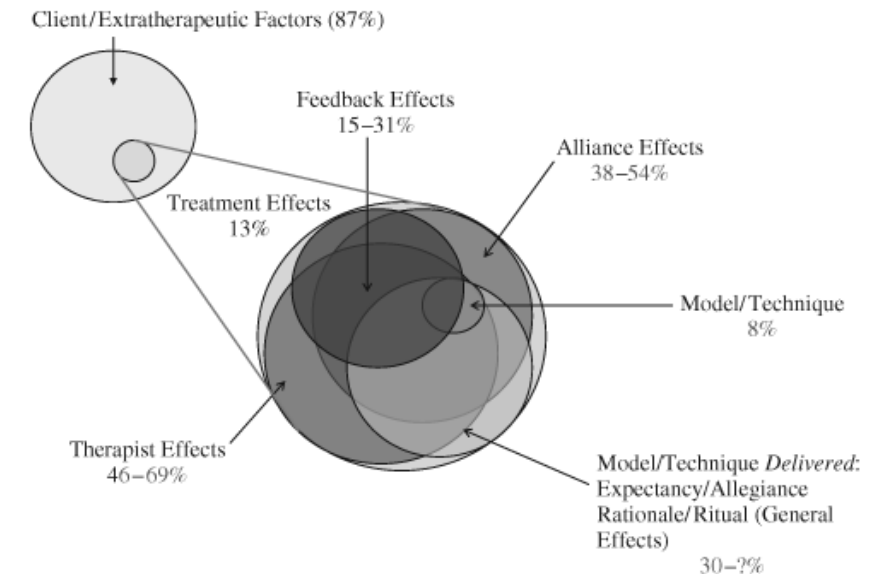
"So finally one begins to wonder whether it would not be natural and also to the purpose to be openly a human being with feelings, emphatic at times and frankly exasperated at other times? This means abandoning all 'technique' and showing one's true colours just as is demanded from the patient." (Ferenczi, 1988, p. 94)

Therefore, I believe that emphasising Ferenczi as a researcher and master of technique is misleading and obscures the essence of his work. Although both Pap and Bohak provide numerous descriptions of Ferenczi's shift in focus from technique to common factors, referring to him as a master of technique implies the opposite. A key characteristic of the biomedical approach is precisely its emphasis on technique or its specific effects, ignoring common factors.

In the following, therefore, I will situate Ferenczi's innovative contribution within the matrix of the theory of common factors and contextual model, including client and therapist factors, therapeutic alliance, feedback, and the effects of techniques (Duncan, 2014, 2017) (Figure 2). The client is the driver and main actor of therapeutic change, with 87% of the client's factors contributing to the impact of the therapy⁴. If we consider the remaining 13% of the effect of psychotherapy treatment equivalent to a new 100%, we can observe that the therapist's effects contribute from 46% to 69%, the therapeutic alliance from 38% to 54%, feedback effects accounts for 15% to 31%, the general influence of the model or technique around 30% and the specific influence sits at 8%.

Figure 2

Common and specific factors contributing to psychotherapy outcomes (Duncan, 2014; Duncan, 2017, p. xvi)



6.1. Client factors

The results of the meta-analyses on common factors suggest that the client is a key player in the success and effectiveness of therapy (Duncan, 2017; Duncan et al., 2004, 2010). This is a major blow to the narcissism of therapists, even an antidote, since throughout the history of psychotherapy the myth of the

4 This 87% also includes unexplained and error variance, which refers to all factors that contributed to the therapeutic change and cannot yet be explained, as well as what we mistakenly interpret as contribution of therapy (Asay & Lambert, 1999).

key role of the therapist has long been perpetuated (Bohart, 2000; Bohart & Tallman, 1999, 2010; Tallman & Bohart, 1999). This exaggerated attribution of importance has been based to a large extent on psychotherapeutic theories. As we have seen, a feature of theory-centred psychotherapeutic approaches is the belief that therapists' knowledge derived from theory is worth more than that of clients. Empirically supported common factors theory, however, turns such a belief on its head and makes it clear that therapy is only successful if the therapist steps down from the superior position of the knower and gives up the illusion that he or she can control the client and the therapeutic process on the basis of theory.

From the point of view of common factors, the 'Clinical Diary' can therefore be read as Ferenczi's visionary humiliation of the therapist and exaltation of the patient. We are referring here to his humiliation of himself in a good sense, i.e. as an example of constructive clipping of the wings of the therapist's narcissism. Therapists tend to give themselves too much importance and credit in the case of successful treatments, while in the case of unsuccessful ones they point the finger at the clients or their '(too) difficult' pathology, which is, on top of everything else, therapists' own invention. And by condescension, we mean Ferenczi's unwavering respect for patients, whatever their symptomatology or presumed mental disorder. To this day, few psychiatrists or psychotherapists have managed to write anything as frank and critical on their own account as Ferenczi dared to do in his 'Clinical Diary'. At the same time, after self-critical reflection and supervision, he returned to his patients again and again with trust, hope and faith, helping them to discover their abilities and resources. Even when they sank into the deepest abysses of regression, he believed that they could rise and tried to do the best he could to help them develop a more complete sense of self:

"The patient must once have the opportunity to be all ego, before his ego is reconstructed on the basis of his own insight. (Up-bringing corrected, replaced by self-education through experience.) Analysis must make possible for the patient, morally and physically, the utmost regression, without shame! Only then will the patient, after he (or she) has enjoyed for a while taking everything for nothing without scruples of conscience, be able to adapt to the facts; even to tolerate maternally (without expecting anything in return) the sufferings of others (goodness)." (Ferenczi, 1988, p. 116)

Most experts who deal with the relationship between Freud and Ferenczi believe that the core of the dispute were Ferenczi's radical clinical experiments with psychoanalytic techniques and his promotion of deep regression in the hope that this would provide the patient with a "new beginning". Ferenczi elaborated on the problems related to regression, which he did not want to exclude or limit.

He was unsatisfied with the rules of the classical technique, which dictated it is necessary to bring the patient out of regression as soon as possible in order to enable him to have a dialogue in adult language, or even try to convince him to stop analysis and find another form of therapy. Ferenczi was convinced that this can only lead to a partially successful therapy that has not touched the client's deeper problems. He felt that the client should be allowed to regress, and even helped to do so. He was sure that a regressed state gives him access to a part of his personality with which he was not in contact before. However, sometimes this position led to a deadlock, along with disappointment, despair, the loss of confidence in the therapeutic relationship, and a premature termination of analysis.

So, Ferenczi also became aware that some aspects of the classic technique of abstinence and frustration should be used, but he himself in many cases could not find the right measure to achieve positive outcome. This worked better for Balint (1969/1992), who elaborated further on his teacher's concept of regression and differentiated between two types of regression that can appear during analysis: 'benign', which is minor, temporary and reversible, and 'malignant' regression, which is major, serious, lasting or even irreversible. The former provides a beneficial, therapeutic effect with the shift out of the regression, also called a 'new beginning', while the latter only leads to an endless spiral of the patient's demands. Even their fulfilment does not bring a solution, as it cannot prevent growing bitterness and frustration, so that everything escalates to insurmountable problems for the patient and the therapy.

Freud perceived Ferenczi's experimentation with regression as risky. He thought he was trying to cure his patients with the love he himself so much longed for. Thus, an unpleasant complication occurred at the end of December 1931, when Ferenczi's patient Clara Thompson confided to Freud that 'Papa Ferenczi' had allowed her to kiss him whenever she wanted during psychoanalysis. Freud then wrote a reproachful letter to Ferenczi about the dangerous consequences of the 'kissing technique', which deeply offended him, and he replied that he had learnt to create an atmosphere free of passion with his patient. Freud's accusations affected him and on 7 January 1932, a good week after receiving Freud's letter, he began to write 'The Clinical Diary' (Bohak, 2022).

6.2. **Therapist factors**

Bohak (2022) notes that Ferenczi was the first to begin to study therapist factors. He emphasised the importance of the psychoanalyst's personality, especially in relation to treatment impasses. He considered the possibility that the patient's resistances are actually a response to the psychoanalyst's countertransference.

He experimented with sharing countertransference experiences with his patients and turning to them for supervisory help. These experiments helped to shed light on the role of the psychoanalyst's subjectivity and the importance and risks of the psychoanalyst's self-disclosure.

Ferenczi was never an emotionally distant therapist who, within the framework of Freud's rule of abstinence, tried to be a blank canvas for the patient's projections. However, when in 1921 he befriended the German physician Georg Groddeck, who placed great importance on body language, emotions and the therapeutic relationship, he became even more open, affectionate, compassionate and benevolent towards his patients under his influence (Pap, 2020). He placed empathy at the forefront of the therapist's considerations. It is therefore not surprising that Paul Roazen, a well-known scholar of the history of psychoanalysis, remembered him as the warmest, most humane and most sensitive of the early psychoanalysts, while Max Eitington - also a member of the first generation of psychoanalysts - considered him 'the romantic of psychoanalysis' (Bohak, 2022). In Ferenczi's human openness in therapeutic relationships with patients today, we can also find many parallels with Yalom's concept of "fellow travelers" (Yalom, 2002, p. 29), where therapist and patient can see themselves in the same boat with regard to confronting fundamental existential questions.

Today, Ferenczi is recognized as a master of psychoanalytic technique and emphatic therapist, from whom many analysts have benefited, including Ernest Jones, Melanie Klein, Clara Tompson and Izette de Forest, to mention only a few. Among the original figures in the early psychoanalytic group in Budapest was Melanie Klein (1882-1960), who, because of her depressive moods, had been in therapeutical analysis with Ferenczi from 1916 to 1920 (Grosskurth, 1986). Encouraged by the latter, while still in Budapest, she began to develop her technique of analysing children's play. She first belonged to the Budapest and then to the Berlin school of psychoanalysts, until she eventually found a new home in 1926 in London (Haynal, 2011).

In order for a therapist to develop genuine empathy, however, Ferenczi believed that a personal experience was necessary for the future psychotherapist before working with his or her clients. He urged psychoanalysts to allow themselves to be emotionally influenced by the patient's associations and to observe their own experience in their analyses and to use this to better understand the patient's content. Thus, Ferenczi is also credited with discovering the utility of countertransference (Pap, 2020, p. 146).

However, Ferenczi's strong focus on building empathic relationships with patients increasingly strained his relationships with other psychoanalysts. This

was most clearly demonstrated at the Seventh International Psychoanalytic Congress in Berlin, where two camps were formed; on the one hand Sándor Ferenczi and Otto Rank with their creative approaches, and on the other Ernest Jones and Karl Abraham with their highly concrete scientific thinking (Pap, 2020, p. 144).

According to Judith Dupont (2023), Ferenczi has placed the psychoanalyst - starting with himself - in a paradoxical position. He wanted every therapist, including himself, to be perfect, but at the same time he was aware that perfection does not exist. Therefore, the therapist must be aware of his shortcomings, take responsibility for them and never stop improving. The therapist must admit that he cannot solve everything, but he must still behave as if all problems can be solved if only he invents the right approach to solve them.

His attitude towards patients in no way stemmed from any paranoid delusions, as Jones claimed. However, it did represent an inclusion in the therapeutic relationship beyond the generally accepted boundaries. Ferenczi tried to compensate for this excess with an immense sincerity that was also supposed to be boundless. He was ready to admit the negative emotions that the patient had awakened in him, especially on a sexual level. He was willing to do all this so that neither of the parties would lose their sense of reality. He always escalated his experiments 'to the point of absurdity', as he put it, even if that meant he had to think it over, and determine more precisely where he should stop (*ibid.*).

After a phase of experimentation with what he called 'active therapy' and 'relaxation', Ferenczi came to the realisation that psychoanalysis requires flexibility in combining and finding the right balance between frustration and gratification, tension and relaxation. As part of his experimentation with relaxation, he confessed to patients his own faults and certain countertransference feelings such as anger and boredom (Bohak, 2022). The therapist should respond to the patient as an 'elastic band', adapting methods and techniques to the patient's needs, rather than the other way around, which is now a central tenet of the common factor theory and the contextual model. He believed that the task of the psychoanalyst is not to select patients who might benefit from his techniques, but that the psychoanalyst must (re)find an individualized approach. Something new had to be invented for each client, i.e. his idiosyncrasy had to be taken into account.

Ferenczi also stressed modesty as a necessary characteristic of a good therapist. It should not be learned, but should reflect the therapist's awareness of the limits of his own knowledge. He saw modesty as the turning point where a 'revolutionary transformation' of the fundamental quality of the doctor-patient relationship could take place, a transition from a biomedical approach

characterised by the doctor's attitude of omniscience and omnipotence (sometimes even arrogance) to a biopsychosocial approach, which should be characterised by modesty:

„Nothing is more harmful to the analysis than a schoolmasterish, or even an authoritative, attitude on the physician's part. Anything we say to the patient should be put to him in the form of a tentative suggestion and not of a confidently held opinion, not only to avoid irritating him, but because there is always the possibility that we may be mistaken. It is an old commercial custom to put (E. & O.E. , (errors and omissions excepted') at the bottom of every calculation, and every analytic statement should be put forward with the same qualification. Our confidence in our own theories should be only conditional, for in every case we may be presented with a resounding exception to the rule, or with the necessity of revising a hitherto accepted theory. I recall, for instance, an uneducated, apparently quite simple, patient who brought forward objections to an interpretation of mine, which it was my immediate impulse to reject; but on reflection not I, but the patient, turned out to be right, and the result of his intervention was a much better general understanding of the matter we were dealing with. Thus the analyst's modesty must be no studied pose, but a reflection of the limitations of our knowledge. Incidentally this may suggest the point from which, with the help of the lever of psychoanalysis, an alteration in the attitude of the doctor to the patient may be brought about. Compare our empathy rule with the lofty attitude to the patient generally adopted by the omniscient and omnipotent doctor..” (Ferenczi, 1994, p. 94)

If we understand Ferenczi's emphasis on empathy, then it is not surprising that he also pointed out the limitations of Freud's concept of 'free-floating attention' or 'evenly suspended attention' (Laplanche & Pontalis, 1988, pp. 43-44). He acknowledged its usefulness in conventional psychoanalysis when the patient speaks about themselves and their experiences from an observer's perspective. However, when the patient experiences pain and suffering directly, especially when reliving trauma, this kind of attention is inappropriate. A therapist in a state of free-floating attention may be perceived by the patient as disinterested, distant and cold — in short, unempathic — at the moment of reliving the traumatic memory. This is why Ferenczi warned that the classical detached and cold psychoanalytic stance can retraumatise the patient.

6.3. **Therapeutic alliance**

The 1919 paper 'On the Technique of Psychoanalysis' (Ferenczi, 2024b) proves that Ferenczi is credited for the understanding the useful value of countertransference. His conception was a precursor to the modern understanding usefulness

of countertransference, as introduced was later confirmed by Paula Heimann, when countertransference is no longer understood as a psychoanalyst's blind spot, but as a valuable experience that can make a bridge to the understanding of patient's unconscious (Bohak, 2022).

Ferenczi also had a significant influence on American interpersonal theory, particularly because of his influence on Clara Thompson, who went through analysis with him. The development of Harry Stack Sullivan's interpersonal theory and its subsequent elaboration into the interpersonal psychoanalysis of Clara Thompson, Erich Fromm, and Frieda Fromm-Reichmann was the earliest attempt to formulate a 'two-person theory' or 'field theory' as a basis for psychoanalysis (Aron, 1990, p. 477). Also Sullivan's students, including Stephen Mitchell, Jay Greenberg and Jessica Benjamin, worked on two-person psychology, which gradually became known as 'the relational school' (The Boston Change Process Study Group, 2010, pp. xiii-xiv).

He described the 'mutual analysis' experiment in detail in 'Clinical Diary' (Ferenczi, 1988). He soon realised all the shortcomings and even the impracticability of this idea and the painful situation into which he had slipped in this experiment. He continued to reflect on mutual analysis until the end of his career. The fact that he was aware of its difficulties and challenges is clear from his 'Clinical Diary', entry 140i from June 3, 1932: "Mutual analysis: only a last resort!" (Ferenczi, 1988, p. 115). Even in the last diary entry, dated October 2, 1932, he thinks about mutual analysis, about the possibility that every analysis, every case, would include at least a certain amount of mutual analysis: "Once mutuality has been attempted, one-sided analysis then is no longer possible – not productive. Now the question: must every case be mutual? - and to what extent?" (ibid., p. 213).

Thus, his experiment with mutual analysis should not be understood as a failure, but as an attempt to find a variety of creative responses to the diversity and idiosyncrasies of patients (Dupont, 2019, 2023). At the same time, Ferenczi maintained a human openness in his therapeutic relationships with patients in the sense of 'existential openness', which was much later emphasised by Yalom (2002) as one of the key qualities of a good therapeutic alliance.

Moreover, thanks to Ferenczi, psychoanalysis has slowly become a 'two-body psychology' or a 'two-person psychology' (Aron, 1990; Rachman, 2016). Although the foundation for it was laid down by Freud in his initial theory of trauma, wherein he viewed trauma as a consequence of interpersonal events, he later modified this view, claiming that his clients' traumas were merely fantasies. It is the 'Clinical Diary', as Dupont (2016, 2019, 2023) points out, that constitutes the phenomenological roadmap of the therapist's gradual journey into the

world of mixed subjectivities and the beginnings of a democratic two-person therapeutic encounter. Ferenczi described his feelings as a psychoanalyst and how these feelings influenced his work with patients. He had the courage to show not only his successes but also his failures and mistakes.

His contribution to the psychology of two played an important role in the development of British object relations theory and intersubjectivism (Szecsödy, 2007). He was the first psychoanalyst to find himself in the field of intersubjectivity. He began to wonder whether the reason for the stagnation or failure of analytical treatment is really always only the patient's resistances, or whether the psychoanalyst's own unconscious content may also be contributing to this. He began to think of his patients' transfers as a co-created reality, as his own co-creation, and he recognised his patients as an important source of information about his own countertransference problems (Pap, 2020).

In 1939, Balint, who had joined the intersubjective line of clinical practice and research during Ferenczi's lifetime, together with Alice Balint, described the psychoanalytic situation as a reciprocal process, anticipating modern theories of intersubjectivity by almost half a century (Balint & Balint, 1939). Like Ferenczi, they described the great variation of ways in which analysts work, confirming one of the key assumptions of the common factor theory, that the technique cannot be implemented in the same way because it depends on the context. They suggested, that despite efforts to adhere to Freud's technical recommendations, analytic technique was far from being universally the same. They also emphasized that it is important to pay closer attention to the vicissitudes of the analytic dyad, because "the analytical situation is the result of an interplay between the patient's transference and the analyst's counter-transference, complicated by the reactions released in each by the other's transference on to him" (ibid., p. 227).

This understanding also brought about the development of the 'Budapest model of supervision' (Bacal, 2016) within the Hungarian school of psychoanalysis. The main assumption was that the candidate's clinical training can be best done if the personal analysis and the supervision are carried out by the same person, that is, the candidate's analyst, at least during the first case undertaken. Later, the British Psychoanalytic Institute allowed Balint to use the Budapest model as long as the candidate's participation was voluntary and another control case was supervised in the traditional way.

6.4. Feedback

Using the theory of common factors, the idea of reciprocity helps us to see how crucial patient feedback was for Ferenczi. If Freud turned to his own theory as a key source of information to guide him towards therapeutic success, for Ferenczi

the main source of information was the patient. He always gave priority to patient's diagnosis and interpretations, however brilliant his own might seem to him. It was in his attempt at mutual analysis that he went to the extreme of giving the patient the role of therapist, analysing his associations, hostile feelings and weaknesses. He thus carried out an exchange of professional roles and thus obtained important feedback from the patient's side about the countertransference problems in their relationship, in order to protect the patient from disapproval and consequent retraumatisation (Pap, 2020).

It is the contemporary findings on the crucial importance of feedback that shed an entirely new light on Ferenczi's experiment with reciprocal analysis. They can help us to see it not as Ferenczi's folly, but merely as the feedback principle carried to its extreme. Yalom is also among those psychotherapists who understand this, and he has masterfully applied the idea of mutual therapy to literary purposes. In his novel *When Nietzsche Wept* (Yalom, 1993), he plays on historical facts to describe the mutual therapy of Breuer and Nietzsche. In the novel *Every Day Gets a Little Closer* (Yalom & Elkin, 1974), he invited his patient to keep her own notes on their sessions in parallel with him, so that they could then publish them together in a book.

6.5. The techniques

In the contemporary psychotherapy literature, there is a distinction between therapist's *adherence* and *allegiance* to a particular method or technique ((Hollon, 1999; McLeod, 2009; Shaw, 1999; Tschuschke et al., 2015; Webb et al., 2010). Research results show that therapist's low adherence and high allegiance in a technique correlate with high treatment efficacy. Patients are much more likely to develop trust in the techniques used by the therapist if the therapist is willing to adapt them to the patient's needs at any time and if the therapist expresses both verbal and non-verbal trust in the chosen technique. And the client's trust and faith are the key to the placebo effect.

Looking at Ferenczi's extensive writings on technique, we can see this combination: that he did not adhere to any technique, as he was constantly developing and adapting them to the needs of his patients, and that whenever he used a technique, he did so with a high degree of allegiance, but also hope that it would be helpful to his patients. It is this combination, which is now desirable for all therapists, that is a large part of the answer to why he was so effective as a therapist that patients flocked to him from everywhere. What mattered was not the technique itself or its specific effect, but the overall effect he achieved through the way he used the techniques and his attitude towards them.

Let's imagine coming to see him for a first discussion about a possible therapy appointment, still undecided and full of doubts about whether we have come to the right place. In a 1928 article entitled 'The Elasticity of the Psychoanalytic Technique', it is clear how carefully and subtly he was attending to the question of how to present to the patient what he could expect from psychotherapy, and how important it was that he should build up faith and confidence in it:

"Analysis should be regarded as a process of fluid development unfolding itself before our eyes rather than as a structure with a design pre-imposed upon it by an architect. The analyst should therefore in no circumstances be betrayed into promising a prospective patient more than that, if he submits to the analytic process, he will end by knowing much more about himself, and that, if he persists to the end, he will be able to adapt himself to the inevitable difficulties of life more successfully and with a better distribution of his energies. He can also be told that we know of no better and certainly of no more radical treatment of psychoneurotic and character difficulties; and we should certainly not conceal from him that there are other methods which hold out quicker and more definite prospects of a cure; and, if patients then reply that they have already submitted for years to treatment by suggestion, occupational therapy, or methods of strengthening the will, we may feel pleased. In other cases we may suggest that they try one of these much-promising methods before coming to us. But we cannot allow to pass the objection usually made by patients that they do not believe in our methods or theories. It must be explained to them at the outset that our technique makes no claim to be entitled to such unmerited confidence in advance, and that they need only believe in us if or when their experience of our methods gives them reason to do so." (Ferenczi, 1994, pp. 90-91)

In this context, we should recall, as Frank (1971), the author of the first contextual model, pointed out, that fostering the client's hope and positive expectations is a key factor of effectiveness in psychotherapy and other forms of treatment. Thus, for the most part (30%), methods and techniques work through the activation of placebo, hope and the client's expectations, combined with the therapist's confidence in the method or technique. As long as the treatment is meaningful for the client and encourages his/her active participation, this or that method or technique does not play a significant role. In other words, therapeutic techniques are means of placebo intervention (Kirsch, 2005, 2010; Kirsch et al., 2009, 2016).

Unlike the biomedical approach, where placebo is undesirable, the reverse is true in the biopsychosocial approach (Wampold et al., 2016). 'Placebology' is a respected field of research, and to the extent that psychotherapists are

placebologists, and learn to exploit it for the benefit of our patients, we are complimenting them. And we can safely say of Ferenczi that he was a master placebologist. Of course, this science did not exist in his time (and is still not sufficiently developed today), but that does not mean that he did not make a significant contribution to it. His dedication to therapeutic and research work, his eros, his therapeutic optimism and his enthusiasm surrounded like a 'placebo cloud' all the 'techniques' he implemented. In this way, he created a circle: his way of applying the techniques helped to develop a healing context, and the healing context he co-created with his patients helped to make the techniques more effective. At the same time, we must also take into account his enthusiastic and tireless attitude towards research into clinical practice, which certainly contributed further to his therapeutic success. Given the level of psychotherapy development at the time, he successfully bridged the gap between research and practice, that remains one of the greatest ongoing challenges in the field.

7.

Epilogue: Ferenczi as acrobat over the abyss

In summary, Ferenczi is now widely recognised as the founder of the Budapest school of psychoanalysis. This school made the following key contributions to the development of psychotherapy:

- "a conception of a field of interactions based on openness and honesty,
- a shift from the exclusive focus on the oedipal triangle to include the mother-infant dyad,
- the recognition of sexual abuse and trauma in infancy,
- a major focus on the analyst's feelings, intentions, reactions, and experiences – countertransference,
- entering the analysand's perspective especially as he/she experiences the analyst,
- a deeper exploration of regressive states,
- (possibly most important) a taste for experimentation in therapeutic approach and supervision" (Lichtenberg, 2016, p. 2).

To conclude, let us consider the metaphor relating to what Lichtenberg identified as the most significant contribution of Ferenczi and the Budapest School of Psychoanalysis: an experimental approach to therapy and supervision. Ferenczi was like an 'acrobat over the abyss' (Lunaček, 2014). He took risks all his life and pursued bold ideas that had never been seen or heard before. If we imagine an acrobat on the trapeze, his perfectly trained body enables him to perform feats that the untrained would not even dare to think of. Yet even a trapeze artist can stumble and fall. He is rewarded for taking risks with roaring applause and an

inner sense of freedom. Unlike the trapeze artist, however, Ferenczi received no applause because his contemporaries were unaware of the risks he was taking.

Today, we realise the magnitude of the risks Ferenczi took when he confronted the issue of countertransference. It opened up before him like an abyss. Despite repeatedly stumbling into it, he returned to the trapeze. But he missed the applause. It did not come until many years after his death. Those with a similar fate can take consolation in the fact that it is the creative activity itself that is important, not the applause. Applause is a double-edged sword because it can reflect blind, single-minded thinking. Therefore, silence in the absence of applause may be the best reward. It is in its shelter that the greatest minds find company.

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