Ferenczi's Turn in Psychoanalysis
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Introduction to Ferenczi

Despite the certainty with which its theory is frequently presented, psychoanalysis is not a fixed body of knowledge; it is rather many theories, some compatible with what Freud wrote, some not, and with many hiccups and inconsistencies, particularly as infant research and neurobiology have been incorporated into the analyst's working vocabulary. Nor is it a single established technical practice; it is, again, many techniques, despite persistent efforts to "uphold standards" and to distinguish the "pure gold" of psychoanalysis from the serviceable but cheapened "alloy" of psychotherapy. Psychoanalysis now comprises over a hundred years of accumulating, hard-won (and painfully lost) clinical and personal experience. Some of what has been accumulated can be taught to new generations of psychoanalysts and psychotherapists, but because the analyst is his or her own instrument (and each one of us, like it or not, is different), a certain amount of reinventing the wheel is not only unavoidable but also desirable if psychoanalysis is to remain a fresh, viable, and inventive discipline.

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Until quite recently, Sándor Ferenczi (1873–1933), who in 1908 joined the small group of Freud's early adherents, was counted among the lost pioneers of psychoanalysis. In his biography of Freud, Ernest Jones described Ferenczi as "the most brilliant . . . the one who stood closest to Freud" (1955, 157). Also until recently, the majority of his contributions have been thought to belong to the classical tradition of psychoanalysis. John Gedo (1976) has deemed Ferenczi's work prior to 1930 as second in importance only to Freud's. The proper measure of Ferenczi's relationship with Freud is their voluminous correspondence, which consists of over a thousand letters exchanged uninterruptedly over twenty-five years until Ferenczi's death, despite growing tensions between the two men after 1927. The publication of Ferenczi's Clinical Diary (1985), moreover, has provided an impetus to reevaluate his contributions after 1930 and to reconsider his role in the development of psychoanalysis.

From empirical beginnings, Freud laid down a theoretical system for describing the contents and structures of the mind in both its conscious and unconscious aspects. During his lifetime, the notion of psychoanalysis began to shift from being principally a tool for psychological investigation to having treatment as its ultimate aim, so that the purpose of theoretical innovation was to improve the therapeutic result. Michael Bálint wrote that "although the technique of psychoanalytic treatment was perhaps Ferenczi's favorite topic and occupied his creative mind most of the time during his analytical career, it was always the treatment itself that mattered to him and never the working out of a tidy system" (1967, 147). At the outbreak of World War I, when analysts found themselves without patients, Ferenczi had three brief periods of what he came to regard as a "training analysis" with Freud in order to supplement his own self-analysis. Although to the end of his life he remained painfully aware that this analysis had been incomplete, Ferenczi greatly valued it, particularly for the profound effect of his firsthand exposure to the experience of transference. When he resumed his own clinical practice after the war, it was with a heightened sensitivity to how transference felt to the patient.

In the aftermath of his analysis with Freud, Ferenczi began thinking about countertransference, noting its presence in the development of psychoanalytic theory and practice as well as in the immediate subjective
experience of the analyst. Henceforth he questioned Freud's negative notion of it purely as a hindrance to be suppressed and sought to recognize it as a major factor in all analyses, which needed to be dealt with without hypocrisy. Ferenczi's experiments with therapeutic uses of the countertransference contributed to his escalating tensions with Freud after 1927.

The controversies surrounding Ferenczi since his death have likewise in the main concerned his technical experiments—above all, mutual analysis—for which we now have the indispensable primary source in the Clinical Diary. So trenchant are the observations recorded in the Diary that it is easy to forget that Ferenczi did not intend it for publication. Ferenczi devised the experiment of mutual analysis "as a last resort to keep alive the analyses of a few patients who had been severely traumatized as children" (Vida 1991, 272). The seven major papers Ferenczi wrote after 1927 all grew out of his work with these patients; in them he began to move beyond the cul de sac in the conceptualization of treatment implicit in Freud's one-person psychology. Ferenczi's ideas about countertransference were far ahead of the theory, practice, and discourse of his own time, and they sounded crazy to his contemporaries. His rethinking of the pathogenesis of trauma, initiated in "The Unwelcome Child and His Death Instinct" (1929) and "Child Analysis in the Analyses of Adults" (1931), reached its culmination in "The Confusion of Tongues between Adults and the Child" (1933), the paper that Freud asked Ferenczi not to present at the Wiesbaden Congress (Rachman 1989). After Ferenczi's death, Jones quietly kept "Confusion of Tongues" from being published in the International Journal of Psycho-Analysis, and it did not appear in English until 1949. The paper describes the child's biphasic traumatization by the (primarily sexual) transgressions of adults, the second and more insidious phase of which involves the disavowal by adults that any harm has occurred. The child, left alone and uncomprehending, undergoes an internal splitting: a traumatized part is abandoned, another part takes on the adult's disavowed guilt, and yet another part identifies with the adult as a kind of self-protection.

The Wise Baby

A concept developed by Ferenczi with which he has often been identified is that of the "Wise Baby." Apart from being applied to Ferenczi himself,
however, little clinical use has been made of this concept. Such autobiographical readings as it has been given, moreover, have often been used to "diagnose" Ferenczi's "pathology" and served not just to explain but to explain away the prescience of his insights regarding treatment. Jones, for example, speaks of Ferenczi's "childlike nature" and "insatiable need to be loved," which, however, were inseparable from his "lack of critical judgment" (1955, 157). Even Bálint, Ferenczi's staunchest supporter, invoked the Wise Baby metaphor to interpret Ferenczi's estranged position in the memorial essay he wrote to accompany the first English translation of "Confusion of Tongues" in 1948.

To allow a more complete understanding of this concept of the Wise Baby, it is worth quoting in its entirety the brief communication in which Ferenczi first coined the term. It appeared in German in 1923 in the Internationale Zeitschrift; the English translation that follows is by Olive Edmonds and was published in 1926 in a volume compiled by John Rickman for which the principal translator was Jane Isabel Suttie. The title is "The Dream of the 'Clever Baby':"

Not too seldom patients narrate to one dreams in which the newly born, quite young children, or babies in the cradle appear, who are able to talk or write fluently, treat one to deep sayings, carry on intelligent conversations, deliver harangues, give learned explanations, and so on. I imagine that behind such dream-contents something typical is hidden. The superficial layer of dream-interpretation in many cases points to an ironical view of psychoanalysis, which, as is well known, attributes far more psychical value and permanent effect to the experiences of early childhood than people in general care to admit. The ironic exaggeration of the intelligence of children, therefore, expresses a doubt as to analytical communications on this subject. But as similar appearances in fairy tales, myths, and traditional literary history very often occur, and in the painter's art are also effectively represented (see the Debate of the young Mary with the Scribes), I believe that here the irony serves only as a medium for deeper and graver memories of their own childhood. Therefore the wish to become learned and to excel over "the great" in wisdom and knowledge is only a reversal of the contrary situation of the child. One part of the dreams of this content observed by me is illustrated by the pithy observation of the ne'er-do-well, when he said, "If I had only understood how to make better use of the position of the baby." Lastly, we should not forget that the young child is familiar with much knowledge, as a matter of fact, that later becomes buried by the force of repression. (1923, 349–50)

Ferenczi modestly adds in a footnote: "I do not believe that this communication has in any way exhausted the interpretation of this type of dream."
Ferenczi continued to develop the concept of the Wise Baby in the decade before his death. In "Child Analysis in the Analyses of Adults" he described how "the split-off intelligence of the unhappy child . . . behaved like a separate person whose duty it was to bring help with all speed to a child almost mortally wounded." He went on to comment: "It really seems as though, under the stress of imminent danger, part of the self splits off and becomes a psychic instance self-observing and desiring to help the self, and that possibly this happens in early—even the very earliest—childhood. . . . It is of course not every such child who gets so far in mastering his own pain" (1931, 136). Ferenczi here is saying that although all traumatized children may experience a splitting of intellect and feeling, they do not all have the capacity to become "Wise Babies," in the fullest sense of the concept.

Among the Notes and Fragments, which are isolated jottings in a telegraphic style published in English in 1955 and often pertain to matters in the Diary, there is an entry from April 9, 1931, entitled "The Birth of The Intellect." I shall give extended extracts:

Aphoristically expressed: intellect is born exclusively of suffering. (Commonplace: one is made wise by bad experiences; reference to development of memory from the mental scar-tissue created by bad experiences. Freud.)

Paradoxical contrast; intellect is born not simply of common, but only of traumatic, suffering. It develops as a consequence of, or as an attempt at, compensation for complete mental paralysis (complete cessation of every conscious motor innervation, of every thought process, amounting even to an interruption of the perception processes, associated with an accumulation of sensory excitations without possibility of discharge). What is thereby created deserves the name of unconscious feeling. (1932, 244)

Ferenczi continues:

Here we are faced with intellectual super-performances, which are inconceivable psychologically and which demand metaphysical explanations. At the moment of transition from the state of life into that of death there arrives an assessment of the present forces of life and the hostile powers, which assessment ends in partial or total defeat, in resignation, that is to say, in giving oneself up. This may be the moment in which one is "half dead," i.e., one part of the personality possesses insensitive energy, bereft of any egoism, that is, an unperturbed intelligence which is not restricted by any chronological or spatial resistances in its relation to the environment; the other part, however, still strives to maintain and defend the ego-
boundary. This is what has been called in other instances narcissistic self-splitting. In the absence of any external help one part of this split-off, dead, energy, which possesses all the advantages of the insensibility of lifeless matter, is put at the service of preservation of life. . . .

*Pure Intelligence* is thus a product of dying, or at least of becoming mentally insensitive, and is therefore in principle madness, the symptoms of which can be made use of for practical purposes. (245–46)

In entries of the *Clinical Diary* between January and August 1932, Ferenczi employs clinical material to elaborate his notion that precocious intelligence originates in a traumatic rupture between feeling and thinking, a rupture which similarly may give rise to obedience and adaptation. These reflections chart Ferenczi’s awareness of his own “intellectual superperformances,” as well as those of his patients. A counterpoint is provided by an entry for June 16, 1932, in which Ferenczi posits that healthy narcissism—“that is to say the recognition and assertion of one’s own self as a genuinely existing, a valuable entity of a given size, shape, and significance—is attainable only when the positive interest of the environment. . . . guarantees the stability of that form of personality by means of external pressure, so to speak. Without such a counterpressure, let us say counterlove, the individual tends to explode, to dissolve itself in the universe, perhaps to die” (1985, 128–29).

In “Confusion of Tongues,” Ferenczi analogously writes: “The fear of the uninhibited, almost mad adult changes the child, so to speak, into a psychiatrist, and in order to become one and to defend himself against dangers coming from people without self-control, he must know how to identify himself completely with them. Indeed it is unbelievable how much we can learn from our wise children, the neurotics” (1933, 165). Finally, among the *Notes and Fragments* there is an aphorism recorded in November 1932: “The idea of a wise baby could only be discovered by a wise baby” (1932, 274).

In the following section I shall introduce some material concerning a patient of mine whom I have come to recognize as a “Wise Baby.” Although Ferenczi’s work informed the theoretical background of the treatment, the treatment itself suggested some additional dimensions, which were absent in Ferenczi’s original construct, with both historical and clinical consequences. Is it sufficient to say that wisdom results *purely* from trau-
matic experience? Indeed, I suspect that Ferenczi's characterization of precocious intelligence as a pathological by-product served a self-deprecating function that may have made it easier for others to undervalue his work and, unwittingly and regrettably, contributed to a now widespread notion that it is a sign of pathology for children to have extraordinary intelligence.

**Clinical Material**

Dr. J de A, a married computer scientist in his mid-thirties, sits in my consulting room for the first time, mildly anxious, definitely wary, and speaking of his troubled introspection in subdued, carefully poetic language. Before seeing me he has consulted a younger analyst who, upon hearing the principal concerns and an abbreviated history, seems too quickly to leap to the judgment that psychoanalysis is indicated, at an initial frequency of four times a week. Dr. de A balks at such swift certainty and declines the recommendation, whereupon my name is given to him as someone else he might interview for treatment. Now sitting opposite me, Dr. de A's primary concerns, of painful moodiness and uncertainty about himself in both work and family relationships, seem eclipsed by the impact on him of the analyst's recommendation. Such presumption in his view begs the question of whether help might be possible at all. I am supportive of his requirement to test out the working relationship, rather than to make a commitment without knowing the person with whom he is dealing. Dr. de A has a question that crystallizes his concerns: "Are you smart enough to work this out with me?" I do not hear this as a challenge; what I hear is urgency tinged with despair. His is a legitimate question. I reply: "At this point, there's no way for either of us to know. That's something we'll have to find out." I realize I am quite stimulated by this exchange. I imagine I can see why my colleague was so eager to take this man into intensive treatment, yet it is clear to me that each step will need to be explored and validated as we go. Am I smart enough? I see already that this man is prodigiously gifted. The question is a little scary.

Dr. de A has a high-level position in a large corporation at the cutting edge of technology. He has sophisticated management responsibilities in addition to being the driving force behind several controversial long-term
research projects. It is highly unusual for a single individual to have this combination of duties, but Dr. de A has not just survived in this position. During the ten years since joining the company, freshly armed with a prestigious doctorate, he has risen steadily and dramatically through the ranks to have now surpassed some of those who hired him. Dr. de A observes that he sees things in quite a different way from his colleagues and superiors, and is perturbed by the darkly pessimistic, self-critical conclusions he draws. His career trajectory is at once self-evident and mystifying to him.

Dr. de A is his parents' third child; his sister and brother are twelve and ten years older, respectively. He grew up in the Pacific Northwest, where his father was a narrow-gauge railway engineer who suffered unfathomable depressions until his death some ten years ago. Locked into a monotonous job, Dr. de A's father struggled all his life with feeling unwanted and out of place. The father had been born a twin, but his brother died when they were two. The father's mother, Dr. de A's paternal grandmother, driven cold with grief and rage, proclaimed loudly that the wrong twin had died and never again addressed her surviving son by his preferred name. What eventually gave some focus to the father's life was the dogged pursuit of amateur scholarship. He studied the Civil War, the history of Native Americans during the settlement of the West, and the Holocaust. Each provided a rich avenue for developing and refining his identifications with the unwanted. Dr. de A said, "My father, weak and crippled as he was, I respected a great deal, but he had been beaten down over life with no hope of coming out. My father felt deeply, but converted it into a personal sense of loss and failure by comparing himself with others."

Dr. de A's mother was a housewife. Her dismay at finding herself pregnant again, with him, had far-reaching consequences. The paternal grandmother, with whom Dr. de A's father eventually severed all ties, tried to persuade her daughter-in-law that this inconvenient pregnancy would produce an extraordinary child. Instead of becoming emotionally reconciled to the pregnancy, Dr. de A's mother concretely incorporated her mother-in-law's notion by evolving a pattern of communication in which Dr. de A's accomplishments are the only topic on which he himself is permitted to engage her. A current example: Dr. de A calls to ask if she can
babysit his children on a particular evening; she is busy, or she cannot possibly do it for unspecified reasons. If she hears, however, then or later, that the reason for the request is to allow Dr. de A and his wife to dine with an important corporate executive from the East Coast, or for Dr. de A to receive recognition from one of his many professional societies, she reverses her previous decision without a blink and proceeds to pump him for details.

His mother was both contemptuous and long-suffering about his father's depressions and made the youthful Dr. de A her substitute companion. Dr. de A eventually observed: “There was something in my mother that was as dangerous as can be imagined, and it was deftly hidden beneath an outward facade of having a completely oppressed way of behaving. She was never the source of any of the conflict, which was even more menacing because it was not clear.” At the end of one of our earliest sessions, Dr. de A said: “I think the problem with my mother has to do with ‘penetration.’” Perplexed, I said: “Well, we've got plenty of time to take that up eventually.” In fact, we did not take this theme up until four years later, when Dr. de A resumed treatment after an interruption lasting nearly a year.

Dr. de A’s siblings are so much older than he that initially he had little sense of their roles in his life as a child, and even now in adulthood he feels little warmth or connection with them. He has a besetting sense of strangeness about his family and feels that there were many experiences that didn't make sense.

Within a few months of beginning our work, a pair of events came to light that are probably linked, since both date from the same time.

*Regarding the first:* Dr. de A’s earliest memories are of feeling strange and bewildered, and of puzzling over it. One day, when he was four, he had an idea that made great sense to him. Filled with pride and accomplishment, he burst into the kitchen where his mother had climbed up to get something from a high cupboard, and announced happily, “I've finally figured it out. I'm unwanted!” His mother’s response was at first blank and silent; presently, however, she began to talk about something else altogether. Remembering and retelling this evoked humiliation and further bewilderment. I myself felt shocked speechless.

*Regarding the second:* Dr. de A fell ill as a four-year-old. (We came to
suspect that this happened after the kitchen scene.) There were many visits to the doctor and many medicines, to no avail. Nobody knew what was wrong. Dr. de A became weak, listless, lethargic, and eventually did not get out of bed at all. His mother set up a bed near the kitchen so he could watch her. Dr. de A remembers a blank calm in his mind; he could see no end to this state. Dr. de A believes this continued for a protracted period, certainly for weeks, and possibly months. One day there was a surprise visitor; his mother said, “Santa Claus is here to see you!” Instantly, Dr. de A knew that this was a trick. It was summer; this could not be Santa Claus. Santa Claus gave him a pep talk. “What’s a big strong boy like you doing in bed? Don’t you want to be up and running around? Having fun? There are so many things to look forward to. I’ll be bringing you a lot of great presents at Christmas,” etc. Dr. de A knew his mother had somehow set this up, that Santa Claus was lying to him, and that Santa Claus was a lie. At the same time, he could look down the path of his own private thoughts and see nothing but a dead end. So he decided to accept this as a way out, at least a way out of bed. He recalls being extremely clear-headed about his decision. The way out of bed was to accept that life is a lie; to stick to his own truth meant no life at all. And thus, with no joy, he did leave his bed.

It is beyond the scope of this chapter to fill in the many trenchant details of subsequent events in Dr. de A’s life and how he came to understand them; some, however, are highly relevant. It would not be correct to say that Dr. de A became “emotionless” after Santa Claus’s visit, but a dramatic reordering of his sense of the world did take place. Nothing and nobody were to be counted on, but not in a paranoid sense; rather, the concepts of depending on and expecting understanding ceased to have any meaning. Not long after entering school, he asked what was the hardest thing for grown-ups to do. Upon being told it was computers, he determined to study them, although he had to make do with ordinary arithmetic and science classes for a long time, and his intuitive, highly creative efforts at problem-solving repeatedly ran afoul of teachers with limited understanding and conventional expectations for student performance. By the time he graduated from high school he had developed a huge capacity for persistence and making things happen, which would fuel his adult life in college, in graduate school, and now in his work. But this came at a great emotional
cost, observable to none but him. His singlemindedness was less useful in his personal life. A youthful first marriage to a vain, self-involved woman, whose affairs were common knowledge to everyone but Dr. de A, ended painfully after a few years, leaving him feeling even more bewildered and out of place. In the aftermath, an attempt at therapy proved no less unfortunate when the therapist, an older woman, pressed Dr. de A to become more and more personally involved with her. When he definitively rejected her sexual advances, she became enraged and he fled. Now a second marriage, to a calm but lively and intuitive woman, is proceeding successfully and they have a much-loved and extremely bright child, although Dr. de A remains worried that his black moods and internal self-doubts, in which he questions every one of his perceptions until it seems that nothing remains, will exceed the tolerance of his new family and destroy it.

This treatment began some years ago. Shortly after the initial sessions, a frequency of twice a week was established and Dr. de A chose to use the couch after I explained that the recumbent position could be helpful in focusing awareness of internal processes. For about a year we were able to add a third session, but financial difficulties necessitated a return to twice a week. Because of his job, Dr. de A was required to travel frequently and without a lot of warning. However, he did have some flexibility. What we worked out was a system of make-up sessions that was quite successful, if not entirely predictable: some weeks he had one or two sessions (rarely none); in others three or four. It often happened that during periods when circumstances enabled a greater number of weekly sessions, we entered into much deeper, more archaic material. When there were interruptions in the ordinary flow, Dr. de A would return having worked hard in a sector of his mind while he was away. We would pick up not where we had left off, but at the new place he had come to.

To go on discussing Dr. de A's treatment in this fashion, by focusing exclusively on him, would assuredly be fascinating, but it would reproduce metaphorically his traumatically induced split and perpetuate what he hated about a traditional psychoanalytic approach. This way of working, we also discovered, created for him a virtually exact replica of the scene in the kitchen with his mother. What became quickly apparent as we began to proceed together was that purely intellectual understanding from me was of
no use to Dr. de A, but neither was a situational empathic murmuring. To make an impact, I had to offer both support and insight with a content that Dr. de A had not previously thought of. Dr. de A's besetting need was to be taken in emotionally, to feel understood over and over again as the essential step in accumulating evidence that he existed, that he was real. As he expressed it to me repeatedly, "Understanding can only be demonstrated by taking it one step further." I never knew ahead of time or while it was happening whether I would be able to meet this challenge. When I failed, it never sufficed for Dr. de A simply to wait. I would need him to get agitated, to cry out, as it were, in pain, and somehow something would begin to shake loose inside me and I would be able to say something that I hadn't thought of before—words or an idea would suddenly shape themselves around a vague or not so vague somatic feeling.

In fact, anticipating a session with Dr. de A was a complex experience. On the one hand, I looked forward avidly to the richness and the stimulation; at the same time, and increasingly so as we got into a phase of reliving the experience of his illness at the age of four, I had a visceral feeling of dread. What we learned together was that while the choice presented to him by Santa Claus could be intellectually understood as being superficially between the hopeless depression of his father, who saw the truth, and the dangerously mindless self-deception of his mother, at bottom it was really a choice between life and death. As a four-year-old, he had entered what was probably a marasmic state, and it was horrific for him to relive it and for me to be with him. He would sit up on the couch at the end of a session, and I could see him pack up his anguish and carry it out the door. It was extremely painful to witness.

I had been reading Ferenczi, including the *Clinical Diary*, newly translated into English, when I began work with Dr. de A. That discovery, combined with personal experiences with "severely gifted" children who have had their giftedness treated as pathological or unreal by well-meaning parents and teachers, informed my conscious and preconscious thoughts. I began with the premise that room needed to be made for the assimilation of the exquisitely painful consequences of what his intellect knew. Confirmation of the usefulness of this approach came early. In the fourth month of treatment, Dr. de A said, "It was so helpful for you to say that it's not
going to work to try to fix things by adjusting my thinking to what everyone else sees. It's liberating because I've struggled for so long to try to see things the way others do. To imagine that there's something legitimate about my way of seeing things is remarkable." With this declaration, we launched into the first layer of reentering his experience as a four-year-old, and the phrase "the wise child" crept into my notes and interpretations. What began to be conceptualized was his terrible dilemma as a four-year-old, which he had seen with uncanny clarity (although the full meaning of it was just now being grasped), that he could not go on as a whole person; some vital part of him would have to be jettisoned. In simplistic terms, it could be said that he faced a choice between Thinking and Feeling; but if he chose Feeling, there did not appear to be enough in his environment to sustain that part of himself and he might literally die. It felt as though he had "chosen" Thinking, and now in his analysis he very badly needed enough safety to consider that he might, after all, have made a mistake. (Suicidal games that he played as a ten- and eleven-year-old were not remembered until well into the second phase of treatment, some four years later.)

After a dream of himself as a compartmentless sphere containing the skeleton of a child, some signs of life began to show. We came to understand a menacing dream of an eel surfacing from the depths of a pool as a picture of his constant awareness of being able to say something that would destroy his father or mother. Turning to me, he asked urgently, "Do you understand how dangerous I can be?" The aftermath of this exploration was his beginning to feel freer and less dangerous. Although he said, "It's hard to put myself into the situation of feeling something instead of witnessing it," he experienced more "black states," which he came to grasp as the essence of what it feels like to be unwanted.

He began to characterize it as being in a Dark Room. The Dark Room, he said, "has exits and entrances and objects which I bump up against and use but there is no sense of what else is there. I'm reacting; I only know myself through what I do. There are lamps, but I'm carrying them around and not turning them on—it's a potential I can't use but the existence of the potential is extremely important—the potential of my worth." I asked if the lamps were connected to his mother, but he said, "No, they are not
representative of something from someone else. One of the most frequent experiences I have is asking the question, am I intellectually capable? Is my mind functional? Over the last year in treatment, talking about my father, mother, sister, brother—I’m having a sense that there’s a reason the lights are off . . . I don’t think the lights are going to come on. I think that opportunity was lost.” At the next session, he expressed relief: “That’s the first time I’ve tried to communicate what it felt like, and tried to get myself to become more conscious of it, and it’s the first time I’ve succeeded in doing both.” Then he wanted me to enter the Dark Room with him. As I came to understand what he was asking, I realized that it would require my completely abandoning any vestiges of an analytic stance of thinking, observing, or objectifying. It would be surrendering to “pure countertransference,” and it was scary because I, too, would have no signposts. Eventually a phrase from Stolorow, Brandchaft, and Atwood (1987)—“the shifting sands of intersubjectivity”—floated into my mind. Indeed, it felt as though there were no ground under my feet. For comfort, I carried in with me the evidence that others, too, had been there.

It is difficult to say more about the experience of the Dark Room, because leaving the analytic stance behind meant that I deliberately set aside the language it would take to frame things in a form that might convey a clinical understanding. It could probably be said that I voluntarily underwent a countertransference regression. Reflecting on the experience long afterward, I realized that it was, in fact, one of pure mutuality at quite a deep—one might say, primitive—level that involved undefended trust on both our parts. It has occurred to me that an experience such as this could very well have been what Ferenczi and his patient, R.N., had been straining to accomplish in their remarkable experiment of “mutual analysis,” as chronicled in the Clinical Diary. What persuaded Ferenczi to participate was his response to R.N.’s fear and unconfirmed suspicions of his consciously withheld countertransference fear of her. In the mutual analysis, Ferenczi’s openness about these responses and their past and present origins succeeded in enabling R.N. better to trust her own perceptions and, equally important, allowed her to experience Ferenczi as more real. Ferenczi was drawn into confronting the extremity of R.N.’s mistrust of him, and I, in turn, could feel with no protective buffering how terrifying it was for Dr. de A
to risk trust. Ferenczi has been assiduously criticized after his death for his supposed exploitation of analytic relationships for personal emotional gain, but such criticism avoids considering the impact on both the analytic and the relational process of reaching such a state of mutual trust.

Following the experience of being together in the Dark Room over a number of sessions, something was transformed that allowed Dr. de A to become aware through dreams and reflection of the desperate persistence with which he tried to interest his mother, even after he was four, and how consistently he failed. When an interchange between us left me befuddled, and I observed that he was way ahead of me, he became panicky and angry and commanded, “You can’t fall behind!” This episode put him back in the Dark Room, while I struggled to understand. When I finally said that I thought he had insisted that I not fall behind so I would be with him when he needed me, he was struck by how true that felt and commented, “A shroud has lifted.”

During slightly more than three years of treatment, there was a great deal of significant change. Repeated explorations of interactions at work that were internally difficult for Dr. de A revealed that far below the surface he was reliving the scene in the kitchen with his mother. Of course, no amount of reassurance or success in the present could rewrite the scene as it actually occurred. As Dr. de A became increasingly able to distinguish past from present, he eased up on himself internally and began to appreciate the very real limitations in others’ capabilities, which, interestingly, made him less fearful of them. Along with his own coming back to life as a “wise child,” thus recapturing his own sense of wholeness, Dr. de A was able to embrace his wife’s wish for another child.

His wondering about how it would be possible to stop treatment led us to a plan to terminate in four months, shortly after the birth of the second child. Neither of us had any notion that the work was “finished,” but there was likewise no doubt about the usefulness of his taking the opportunity to see how things would go. Furthermore, we agreed that resumption would be possible if or when he wished. We had been through some unusual experiences in the sessions, and I had the idea that I would one day want to write about them. I didn’t say anything about this right away, but he caught me thinking something I was unwilling to say. So I told him what
was on my mind and added that I would need his permission to write about the case. Both his immediate and subsequent responses were striking. He sat up on the couch and reported that my words had had a powerful effect, a validation that made both me and him feel quite distinctly real. Regardless of what or when I might write, he said, the fact that I wanted to meant that he was real to me.

In the first eight or nine months after stopping treatment he came in once to discuss some work-related issues. A year later he asked to return to tackle the next level of his emotional-perceptual concerns, but he laid down some conditions: first, that we would meet face-to-face and at a frequency of once a week, with no suggestion from me that more often would be better; also, that I would accept his need to make the interaction real, as real as sex, though he didn’t know how we would accomplish this. What gave him hope that we could continue was remembering my comment about writing. Next, he felt that it was necessary for him to be free to get as angry with me as he did with others. What made that a difficult prospect was his fear of humiliation, that I would lose respect for him. This condition implied a significant deepening of our working relationship. (At the beginning of treatment he had felt freer to talk to me than to his wife for fear of losing her respect; that relationship was feeling significantly more real as well.) He concluded by suggesting that somehow in the previous phase of treatment we had helped him free up the part of himself that had been identified with his father; now we had to tackle his mother, a much more dangerous business.

Discussion

Ferenczi’s idea of traumatically acquired intelligence owes a great deal to the Freudian conception of development as a forced struggle. Since each stage of development means the renunciation of more primitive pleasures, environmental impingement is essential if progression is to occur, and this impingement is then immortalized internally in the form of unconscious conflicts at successive stages of development. This could be characterized as a theory of development as trauma. In recent decades, Winnicott, Bowlby and his successors in attachment theory, and a veritable army of researchers
have done much to establish and characterize the inborn developmental strivings and the highly variable inborn temperaments and talents of the human infant, and thus to challenge the authority of such a view.

In *Thalassa* (1924) Ferenczi argued that genitality incorporates a fundamental human longing to regress and dedifferentiate into a state of perpetual pleasure in the womb. But it is not fanciful to think that he would have eagerly taken up contemporary ideas about the role of innate, genetically mediated strivings in human development. For in the last year of his life, Ferenczi began to propose radical changes in his theories and to contemplate rethinking the whole basis of the traditional notions of masculinity and femininity. This is documented in the *Clinical Diary* and the *Notes and Fragments*, where in entries of September, October, and November 1932 Ferenczi considers that the anxiety and/or collapse that can follow a stretch of traumatically driven excessive achievement can be usefully treated with opportunities for saturation with play and “waiting for the spontaneous tendency of ‘growth’” (1932, 265). There is real resonance here with Winnicott’s ideas of “spoiling” as a management technique to allow healing and spontaneous resumption of development. In a most intriguing entry, Ferenczi asks, “Is it possible to make friends with the ucs.?” (251).

I have noted that by 1931 Ferenczi did not think that all traumatized children had sufficient intellect to master their own pain; now this needs to be extended to an acknowledgment that not all traumatized children become Wise Babies. My view is that Dr. de A’s intellect was not traumatically acquired, but traumatically distorted by the necessity of its use for survival, in the absence of minimal conditions of emotional safety. These distortions seem to me to have been activated by his traumatic perception that what he knew was dangerous, when he appeared in the kitchen to share with his mother the extraordinary, unanswerable insight of his having been unwanted. This perception was the product of the already long-standing operation of a remarkable intelligence. Ideally, this mother might have found a capacity to respond to her child in a complex fashion that would have allowed the recognition of his insight along with a new emotional contact that energized them both to deal with their common problem. Only thus might Dr. de A’s development have been transformed. As it was, he remained stranded, and he had to rely on his intelligence for defense and
protection. His desire to learn "the hardest thing" was born of his awareness that there was no real help available to him; he had better equip himself to deal with life alone.

So I take issue with some of Ferenczi's notions about the Wise Baby. Just as not all traumatized children become Wise Babies, so perhaps neither are all children with precocious intelligence Wise Babies either. The concept is no less significant for having been incomplete. Alice Miller gives dramatic form to a version of the Wise Baby in *Prisoners of Childhood* (1981). Her principal idea concerns the vulnerability of gifted children by virtue of their unusual sensitivity to being exploited, principally as caretakers, by the pathologically narcissistic strivings of parents. (Miller's omission of any mention of Ferenczi seems less deliberate than suggestive of the obscurity into which his contributions had fallen.)

I too think that the gift of extraordinary innate intelligence is associated with a certain kind of vulnerability, which I identify as an experience of penetration by suffering that is significantly greater than that of a more ordinary child when, for whatever reason, there is an insufficiently responsive human environment. It is the intelligence that allows for the expanded perception of suffering. When this suffering becomes so great and unrelieved that the emotional register must be split off because the pain of preserving it as an experiencing organ is unendurable, what is left of the Wise Baby is a diminished organism. He is likely to "pass" as sufficient if the remaining conscious or accessible parts are capable of constructing a workable system. Dr. de A's system went like this: "I ask a question: Doesn't anything matter? Then I think: I can make things matter. Then I respond: Then I will try to make that happen; I will choose something I can believe in and work to create a world I can believe in. What am I trying to do and what is motivating me? The distinction between past and present is very blurred."

The split-off parts of Dr. de A passed into that realm of "unconscious feeling," which Ferenczi thought was created by the experience of mental paralysis in the face of trauma. As Dr. de A and I have continued to capture those elements in analysis, he is able (1) to feel more whole; (2) to make a sharper distinction between past and present; and (3) to use his intellect more playfully, with less strain, and more for his own purposes. This work is accomplished in the analysis through a process of reliving and reen-
actment. There are now countless episodes, major and minor, in which the kitchen scene has been reenacted, repeated, and relived in the therapeutic context. In fact, for a very long time, each new development began with a confrontation and continued with my failure, but Dr. de A at least did not need to leave the scene and take to his bed. We would hammer at it till something came through. There continued to be some shared anxiety and uncertainty around these encounters, but neither of us was as frightened as we used to be.

Ferenczi's idea of *counterpressure* holds that the stability of the personality as a genuinely existing, valuable entity is sustained by the positive interest of the environment. I think that this is a most useful conceptualization of how Dr. de A has been struggling to get to an experience of both himself and me as real by using metaphors of sex and penetration. Because he never did "get through" to his mother, he had only vague notions of what these words might represent. But he has become clearer. His wife and children feel more real to him, and I have progressed successively from being perhaps harmful to being neutral to being safe but undifferentiated to being possibly (or occasionally) real. Once, during a weekend, Dr. de A experienced a contentless flash of anger at me, which was shortly followed by a suffusion of contentment and attachment to his wife; in that instant he had known that *he* was real, as he had a sense of me as someone with whom he could become angry, because I could receive, hold, and acknowledge his anger.

The combination of extraordinary innate intelligence with its concomitant expansion of vulnerability to suffering means that the Wise Baby, perhaps even more than the "ordinary" child, requires an experience of counterpressure to prevent the overstretching of his capacity to contain his suffering and thus be able to use his intellectual gifts to express his personality and interests. In other words, they must form part of his experience of himself. With the provision of adequate counterpressure, the Wise Baby need not be seen as a pathological distortion of normal development, but as a variant of the developmental process that has a distinct and unconventional pattern of its own.

Ferenczi, I surmise, felt that he had missed a specific experience of counterpressure in his own life. He sought it in his relationship with Freud, with mixed results, and also in his practice, with important consequences
for the development of psychoanalysis that are just beginning to be appreciated. For Ferenczi to have been a Wise Baby in my terms, he, too, had to have had extraordinary innate intelligence, an assumption about him that has not, to my knowledge, been widely entertained. Ferenczi is typically acknowledged to have been gifted in the realm of “intuition,” which has always been devalued, particularly by comparison with Freud’s “genius.” Perhaps we should begin to recognize that Ferenczi’s concerns anticipated and indeed framed the issues of psychological therapy that have only begun to be assimilated more than fifty years after his death. Indeed, Ferenczi has been discredited in large measure because what he saw and foresaw in psychoanalytic practice—both his own and that of others—greatly disturbed the answers, systems, and clarity that his contemporaries, including Freud, were straining to achieve. But a Wise Baby, whether Ferenczi or Dr. de A, has a unique perspective and something valuable to give, and it tends to be painful to know.

Because psychoanalysis will never be a fixed body of knowledge, Ferenczi’s abiding relevance is to have provided the model of an analyst who was able, for a variety of reasons, to experience himself as an open system. Stimulated by that openness, he formulated questions that others could not anticipate; he waited for responses; he allowed himself to be penetrated; and he permitted something new to be created between himself and the analysand. I see this as the process by which a Wise Baby is able to continue his unconventional development. Although Ferenczi’s quest for a supportive counterpressure was ultimately thwarted, it did lead him, early on, to recognize the primacy of the human need for relatedness, which he long struggled to accommodate within Freud’s system. Unfortunately, he died just at the point when he was beginning to find more room for his own insights. To have access to Ferenczi as a valued, trustworthy companion on our own arduous, exhilarating clinical journeys, we do not have to idealize him, but we do need to listen.

REFERENCES

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