THE CURATIVE FACTORS IN PSYCHO-ANALYSIS[1]

II. SACHA NACHT, PARIS

Before we embark on the subject of curative factors, let us briefly recall what we mean by the state of mental health. Mental health as we see it is essentially the ability to live in a permanent state of harmony with oneself and with other people. It therefore implies that there should be a minimizing of intrapsychic conflicts, and consequently the presence of a strong ego; for, as we know, it is the weakness of the ego that leads to a neurosis. To ensure that the ego possesses the strength, control, and flexibility necessary to mental health, Freud has taught us that ' where id was, there shall ego be '; in other words, the unconscious instinctual forces must become conscious, in order to afford life-giving nourishment to the ego.

Psycho-analytic technique is based on these essential ideas, for all methods of curing a sick mind concern the ego and are effected through it. It follows that there should in principle be a reciprocal relationship between theory and technique. However, at the International Congress of 1936 (19) the question was raised whether there was always complete agreement between theory and technique. Today we are asking ourselves the same question even though a quarter of a century has since elapsed.

Perusal of most psycho-analytic publications would lead one to suppose that we analyse our patients today in exactly the same way as we did twenty, thirty, or even fifty years ago. Now the conditions under which we work—the ' context ', shall we say, of the treatment—have changed considerably since then: theoretical knowledge concerning the functions of the ego has greatly deepened and, with few exceptions, the very content of our clinical work has changed. We no longer treat quite the same sort of illnesses as in Freud's day. We all know that Freud elaborated his technical principles primarily through the treatment of hysterical or obsessional cases, that is to say of patients suffering from typical neuroses; whereas today we are primarily treating atypical neuroses, such as para- or pre-psychotics, neurotic characters, or psychopaths. Thus, out of 523 patients examined at the Institute of Psycho-Analysis in Paris in 1959, we could select only 7·2 per cent obsessional neuroses and 1·9 per cent phobic neuroses. In contrast, the number of people suffering from ' mal du siècle '—those who simply find life too much for them—is growing greater and greater. Today man suffers most of all from being unable to give meaning to the world in which he lives, and in consequence, to himself. His capacity to love (and thus his ability to live life to the full) is stifled by an aggressiveness that is continuously nurtured and at the same time repressed by modern life. If he is the victim of conflicts, these are not the same as they were at the beginning of the century. The Victorian era doubtless compelled him to subdue his sexual needs, whereas the world of today above all puts his aggressive energies to the test. It seems that man adjusts as badly to restraint upon the former as upon the latter. No doubt this is one of the reasons why the conflicts man must endure in our day force him regressively back to pre-oedipal phases. And whatever may be the importance given to the so-called ' autonomous ' ego in other respects, it is nevertheless in contact with its environment that the functions of the ego are established and develop.

The relationship of the human being with the world, and consequently the relationship which the patient will of necessity adopt in the analytical situation, is no longer identical with that which held when Freud instituted the technique of psycho-analysis.

Neither our theoretical ideas nor our case material correspond entirely with the technique we use today, a technique which has been almost the same since its inception. Now, if the analyst/analysand relationship is no longer exactly that on which the classical technique was founded, it follows that the classical prescribed attitude of the doctor towards the patient should have been gradually modified to fit the changes the relationship has undergone.

For instance, it is a generally accepted fact

[1] Translation of paper read at the 22nd International Psycho-Analytical Congress, Edinburgh, July–August 1961.

that the analyst uses but one means of action, that of interpretation. Now in this we perceive a considerable discrepancy between theory and practice. As early as 1936 Glover (6) wrote: ' It would seem that we must credit therapeutic effects . . . not solely to interpretation but to interpretation in combination with other factors ' . . . namely, to ' *the humane relation* in the transference ', and again: ' a prerequisite of the efficiency of interpretation is the attitude, *the true unconscious attitude,* of the analyst '. Yet in 1957, at the Paris Congress, where variations in technique were discussed, Eissler (2) asserted that interpretation remained the predominant, if not the exclusive, tool of psycho-analytic technique. For Rosenfeld (18), who was even more categorical, ' psycho-analytic technique relied *entirely* on interpretation '. To this Loewenstein (11, 12) very judiciously replied: ' I doubt whether anyone has ever carried an analysis through to a therapeutically successful end without having done anything else but interpreting '.

For me, this ' anything else ' is not a secondary factor but an essential one, and I have no hesitation in subscribing to Glover's assertion that ' a pre-requisite of the efficiency of interpretation is the attitude, the true, unconscious attitude, of the analyst '.

I would go even further in this direction in examining more closely the subject we have to discuss: that of the curative factors in psycho-analytic treatment. For these curative factors are indeed numerous, as are the researches devoted to one or other of their aspects. Stress may be laid on the indispensable strengthening of the ego—on the necessity of overcoming fear, or of neutralizing aggression—on the modification of the superego or on the necessary termination of the transference neurosis; or again, on the importance of projective experiences in the progress of a treatment. All these curative factors certainly have their parts to play in the successful conclusion of a treatment.

But as I see it, amid the essential problems involved in a course of treatment lies the importance of a *common denominator* of which the integral value can entirely change the final result: I am speaking now of the person of the analyst in so far as he represents and *embodies* a certain deep inner attitude in the analytic situation. It is this deep inner attitude which, in my opinion, is a decisive factor (16), and that is why I have often maintained that it is what the analyst *is* rather than what he *says* that matters. It is this ' presence ' which will determine, for example, the modification of the superego, the process of identification, and above all the minimizing of the subject's habitual ambivalence. The basic relationship of the patient to the analyst springs from what his unconscious *perceives* of the unconscious of the doctor, perhaps even more than the interpretations that are given him. If we summarize the stages in the course of recovery, what do we find? First of all, scattered transference reactions which gradually build up and take shape to give birth to the transference neurosis. (We know that, in the last resort, it is the resolution of this that will mark the cure.)

The whole course of recovery, based on the strengthening of the ego, is brought about by the progressive acquisition of insight. But to gain insight, the ego must be strong enough already to assume it. Now the analytical situation causes regression—deliberately so, to be sure—but regression which, nevertheless, temporarily weakens the ego. This weakened ego becomes increasingly susceptible to fear, which weakens it even more. This would soon result in a terrible deadlock if the patient were really left to himself, with an *absolutely* neutral psychoanalyst, whose main concern was to remain as remote as possible. The subject would rapidly be overcome by fear, the fear we find at the heart of every psychopathological process. In order that fear may be gradually calmed and the progressive acquisition of insight, so essential to the strengthening of the ego, made possible, the ego must have acquired the functional ability to ' neutralize ' aggressive energy, as Hartmann (8) puts it, or, as I should prefer to say, *integrate* it as a driving force, for merely to overcome it is not enough.

Now if the integration of unconscious drives strengthens the ego, as we know it does, it is only possible for this to take place in an atmosphere of peace and *security*: the patient will only find this in a really tranquil relationship with the analyst.

How will the doctor succeed in establishing a relationship of this quality with his patient? In my opinion he should give very few interpretations to start with, because these are more likely to frighten than to reassure the patient at this early stage. That is why it seems necessary to me that *behind* the analyst's silence the patient should sense a watchful presence which *really exists* and is felt as helpful. That is also why, in the relationship between the analyst and the

analysand, the basis for all therapeutic work, what the analyst genuinely and fundamentally is matters more than what he rationally decides to be in regard to his patient.

In this, despite the value I set on the ideas of Alexander (1), I cannot agree with him when he advocates that the analyst should assume a *deliberately predetermined* attitude according to the patient's history. It seems unlikely that anything solid can be built on a foundation chosen in an arbitrary fashion. Moreover, in one of the two cases Alexander produces to support his proposition, the attitude adopted was not at all contrived coldly in advance: giving way to a countertransference impulse, he *spontaneously* adopted a suitable attitude. ' Finally, we must not forget,' wrote Freud, ' that the relationship between analyst and patient is based on the love of truth.'

Thus, that the analyst's attitude may be beneficial, the patient must *experience* it as a deeply true one. And it can only be so if the analyst possesses an open-heartedness as nearly perfect as possible, arising above all from his unconscious, enabling him to be spontaneously and intuitively what he should be at any given moment in the *actual* analytical situation. His attitude should respond to the *immediate* ongoing process, then, and should not have been premeditated. It is in this regard so necessary that the analyst, himself the sole instrument of his technique, should possess a disposition of openness and flexibility. This will enable him to work within the indispensable framework of technical principles and yet create from the analyst/analysand dialogue a *living* relationship between *one* particular person and *another*. He must, of course, rely on his own intuition which springs from innate talents constantly enriched by well-integrated experience. This intuition, and the flexible disposition which excludes all tension, should inspire the underlying attitude of the analyst towards his patient. But this attitude is possible only when the analyst has been able to reduce to a minimum within himself the inevitable, eternal ambivalence of man. Free, as far as possible, from this ambivalence, the analyst can then fearlessly show a genuine human interest. If I say '*fearlessly*', it is because it seems that some sort of fear and the need for protection from it have led certain rules, formulated by Freud, to be transformed into taboos. The observation is not mine. In a letter Freud wrote to Ferenczi we read: ' I considered the most important thing was to say what should *not* be done, so as to avoid anything that may be contrary to the *spirit* of analysis. The result is that the analysts have not understood the elasticity of the rules I laid down and that *they* have turned them into taboos.'

Here, I think, is a clear accusation that comes to us down the years. I wonder if, in our fear of changing ' the spirit of analysis ', we too are not apt to respect certain rules so literally that they are transformed into taboos.

I am thinking here, for example, of the rule of neutrality when strictly applied, and of its corollary, the rule of frustration. If transference is one of the most important factors in treatment —*and it is*—it could only with difficulty originate and develop in a climate of strict neutrality and complete frustration; or else it would take a scarcely desirable turn, as we shall show when we talk about the unresolved transference neurosis.

We know, as Ida Macalpine (13) has shown, that the whole idea of spontaneity of the transference is debatable, and that it is largely influenced by the analytical situation. For Waelder (20), the transference relationship results from two factors: one within the patient, the other outside him. It is determined by technique and *therefore in the last resort by the analyst* since he is the sole instrument of this technique.

The analyst is urged to maintain a benevolent neutrality. But how far can the benevolence go before the neutrality ceases to be really neutral? There is an ambiguity here which has generally been solved by stressing the first term to the detriment of the second. Moreover from the very fact that the analyst *exists* he must be made of a certain substance whose importance could not be strictly reduced to nought without absurdity—no more in short than the matter of which the famous ' blank page ' or ' mirror ' on which the patient projects his fantasy-world.

Thus we see the full importance of the person of the analyst in the genesis, method of procedure, and evolution of this curative factor known as the transference. The very effectiveness of the interpretations depends on the quality of the transference relationship; it is of more value, from the curative point of view, to have a mediocre interpretation supported by a good transference than the reverse. If the patient can discern, behind the apparent and necessary attitude of ' benevolent neutrality ', a genuine benevolence in the analyst, then the interpretation and the progressive gaining of insight, which

is indispensable to the progress of the treatment, will become possible and fruitful.

The deep inner attitude of the analyst is of even greater consequence in the phase on which the outcome of treatment depends: the transference neurosis. An unresolved transference neurosis is, we know, synonymous with failure. But the patient is not the only one responsible for it, as Freud seemed to think. It is probable that the countertransference attitude of the analyst makes him the patient's unwitting accomplice in somehow opposing the termination of the analyst/analysand relationship, that is in opposing the termination of the treatment.

I have said elsewhere (15) that the unresolved transference neurosis was in my opinion attributable to the establishment of a *certain* unconscious relationship between doctor and patient—a relationship made up of an exchange or rather a *convergence* of *complementary* impulses, in which both find unconscious satisfaction. (A frequent example is that in which the unconscious sadistic tendency of the one encounters the masochistic tendency of the other.) The responsibility for this unfortunate situation lies with the therapist, who is the one to prevent the formation of such ties. In my opinion, if his attitude is one of strict routine neutrality it will favour the establishment of a sado-masochistic relationship. It is true that an attitude of gratification would not be better tolerated by the patient if the modification of the superego had not previously been effected, and would prove just as pernicious.

The transference neurosis should be no more than a culminating point in treatment, and the analyst must be on his guard lest it settle down into a structure analogous to the pathogenic cycle: that of frustration—aggression—fear—guilt—self-punishment—masochism. He will manage to do this much better if his interpretations are supported by a correct attitude.

The transference reproduces not only what has been lived out, but what the patient would like to have lived through as well. It is nourished not only by the past, but, within the analytical situation, by what is happening at the present time. If the need for the parents' love, frustrated in childhood, is again fostered indefinitely by an equally frustrating attitude unvaryingly imposed by the analyst, how should the patient give up the need to suffer or to cause suffering in which his neurosis is deeply rooted? It seems obvious to me that only a timely and technically appropriate attitude of gratification can allow the patient to accept his need to love and be loved, and to express it without fear. But this attitude must, of course, be expressed neither in words nor in gestures, but *solely by an inner state of being*. Here again, we see how the deep inner attitude of the analyst can be a decisive curative factor. When it is genuine, it is felt to be so by the patient and thereby proves particularly beneficial.

Freud (4) advised against the giving of gratification in analysis, to prevent both the patient's increasing his tendency to refuse to make progress in treatment and his behaving in a self-punishing way. No one doubts the well-founded evidence of these arguments or their confirmation by experience. But experience teaches us too that what is valid in certain circumstances is not always so in others, and what appears necessary at certain stages of treatment may become an obstacle at others.

I believe I have already said what Alexander (1) calls 'corrective emotional experience' seems to me to be debatable. On the subject of 'integrative experience' Loewald (10) too, underlines the importance of the analyst/analysand relationship. He thinks the analyst should become for the patient a '*contemporary object*'. This can be possible only, in my opinion, if the analyst, by his attitude, explicitly refuses to maintain the climate of frustration beyond the time necessary to set the analytical process in motion.

Whether it is a question of 'corrective emotional experience', 'integrative experience', or what I should rather call '*de-conditioning*', the aim is the same: to lead the subject to act in relation to what is happening in the immediate present, and not in relation to what happened long ago. Is it not then necessary, in order to reinstate the patient well and truly in present reality, that the analyst should give evidence of his own reality as a human being without being paralysed by the rule of neutrality? To avoid certain errors incompatible with the 'spirit of analysis', must one subscribe to this odd idea that presence should become absence?

I have said elsewhere (14) how much certain subjects (rather rare ones it is true) whose ego had been 'distorted', not only by a traumatized psychic reality but by an *actual* reality which was strongly traumatic—I have said how resistant these subjects were to cure as long as their fundamental need for reparation was not satisfied. Now this need can be satisfied in the analytic situation only if the analyst's attitude of gratification, experienced as the longed-for love

of the parents, constitutes what I have called the indispensable ' reparative gift ' without which nothing can be changed in the make-up of such patients.

It is only when these patients unconsciously perceive, or are obscurely aware of, this open and attentive attitude, this genuinely compassionate acceptance, that they have at last the certainty of being understood and accepted with their yearnings. Their emotional climate is in this way changed: and they can at last make their peace, first with themselves and then with the world—in a word, they in their turn can love. ' Finally,' wrote Freud, ' one must love in order not to be ill, and one becomes ill if misfortune makes it impossible to love.' Therein for many human beings lies the secret of the acceptance or the rejection of life.

This fundamental need to love and be loved goes beyond the first simple experience of man—that of childhood. Man is *afraid* when he feels *isolated*; he seeks unity and fusion in a soothing whole. That is why Ferenczi (3), towards the end of his life, insisted on the importance of the patient's finding in the analyst the love his parents had denied him. This love will give the analyst's ' permissive attitude ' its full value—an essential factor in the modification of the super-ego. If this permissive attitude is rigidly fixed in ' neutrality ', how can it be effective?

The same thing holds true for the process of projective experiences. If the analyst is not *perceived* (I say ' perceived' advisedly and not ' invested ') as a *good* object, how can the patient himself become better, in the process of introjecting him or identifying himself with him?

We all acknowledge that the analyst's interventions are fruitful inasmuch as he succeeds in communicating with the patient's unconscious—to the point of literally being able to ' put himself in the patient's place ' while remaining in his own. Why should the patient as well not have a certain communication with the therapist's unconscious, allowing him to perceive what is his real, underlying attitude? My experience leads me to believe that there indeed exists communication from unconscious to unconscious in both directions. For instance, it comes about that the patient says: ' I know you don't approve of what I am bringing you now.' It will be in vain for the therapist to analyse the material and then call upon his neutrality to help him, if he really feels as the patient thinks he does. The patient's uneasiness will persist, for unconsciously he perceives the unspoken disapproval. It is precisely these exchanges between one unconscious and another which form the strongest bond in the analytical relationship. The essence of this relationship lies, therefore, *beyond the verbal level.* The spoken word is, at least at the beginning of treatment, an element which confirms and increases the *separation* between them—and separation, as we have said, engenders fear. Only this other form of relationship, the non-verbal, can be felt as reassuring, provided the object is felt as ' good ' (14).

I am not unaware that these ideas imply an extreme inter-subjectivity which is, on the face of it, contrary to the scientific spirit, for which pure objectivity is essential. But surely, no science would deny that true objectivity lies in admitting the real nature of something and its correct solution, whatever may be the path which has led there.

I have had the experience, as we all have, of treating successfully patients who have been treated unsuccessfully by a colleague. And yet the former analyst had conducted the treatment correctly, and I have been led to ask myself: ' What did I do more than he?' I have also had the experience of being unable to cure a patient, and asking myself what I did *less* for him than for others. For a long time this problem worried me, until I reached the conclusion that in one case or the other it was to my own deep underlying attitude towards the patient that I had to attribute the responsibility of success or failure. No one can cure another if he has not a genuine desire to help him; and no one can have the desire to help unless he *loves*, in the deepest sense of the word. I certainly do not wish to fall into psycho-analytic pseudo-evangelism. But to quote the words of Hippocrates (15): ' Many patients, conscious of the danger they are in, recover their health solely through the joy their doctor's *kindness* inspires in them.' The analyst's attitude, when it is one of *unconditional* kindness, becomes then, and only then, that support and strength necessary to the patient to conquer the fear which bars the way to recovery.

* * *

This paper may seem to have strayed a long way from the proposed subject, the curative factors in psycho-analytical treatment. Doubtless I have said little of the classical curative factors on which, as I know, there is a great deal yet to be said.

But by focussing this paper on the importance

of the *real*, deep inner attitude of the doctor, I wanted to stress that one thing which in my opinion serves to catalyse *all* the curative factors. Placed at the very centre of the treatment by the analytical situation, is not the person of the doctor in its modest way comparable to the famous 'unmoved mover' of Aristotle? For it is around him that the various processes are ordered and connected: processes that set the patient on the road to recovery.

REFERENCES

(1) ALEXANDER, F. (1950). 'Analysis of the Therapeutic Factors in Psychoanalytic Treatment.' *Psychoanal. Quart.*, 19, 482–500.

(2) EISSLER, K. R. (1958). 'Remarks on Some Variations in Psycho-Analytical Technique.' *Int. J. Psycho-Anal.*, 39, 222.

(3) FERENCZI, S. Letter. In: Jones: *Life and Work of Sigmund Freud*, 3. (London: Hogarth, 1957.)

(4) FREUD, S. Papers on Technique. *S.E.*, 12.

(5) —— 'Analysis Terminable and Interminable.' *C.P.*, 5.

(6) GLOVER, E. (1937). 'Contribution to Symposium on the Theory of the Therapeutic Results of Psycho-Analysis.' *Int. J. Psycho-Anal.*, 18.

(7) GODEL, R. *Une Grèce secrète.* (Paris: Gallimard, 1960.)

(8) HARTMANN, H. (1952). Contribution to Symposium 'Mutual Influence in the Development of Ego and Id.' *Psychoanal. Study Child*, 7.

(9) HARTMANN, H., KRIS, E., LOEWENSTEIN, R. (1946). 'Comments on the Formation of Psychic Structure.' *Psychoanal. Study Child*, 2.

(10) LOEWALD, H. W. (1960). 'On the Therapeutic Action of Psycho-Analysis.' *Int. J. Psycho-Anal.*, 41.

(11) LOEWENSTEIN, R. (1958). 'Remarks on Some Variations in Psycho-Analytic Technique.' *Int. J. Psycho-Anal.*, 39, 202.

(12) —— (1958). 'Variations in Classical Technique: Concluding Remarks.' *Int. J. Psycho-Anal.*, 39, 240.

(13) MACALPINE, I. (1950). 'The Development of the Transference.' *Psychoanal. Quart.*, 19, 501.

(14) NACHT, S. (1958). 'Causes and Mechanisms of Ego Distortion.' *Int. J. Psycho-Anal.*, 39, 271.

(15) —— (1958). 'La Névrose de transfert et son maniement technique.' *Rev. franç.*, 22.

(16) —— 'La Thérapeutique psychanalytique.' In: *La Psychanalyse d'aujourd'hui.* (Paris: Presses Univ., 1956.)

(17) NACHT, S. and VIDERMAN, S. (1959). 'Du Monde pré-objectal dans la relation transférentielle.' *Rev. franç.*, 23. (*Int. J. Psycho-Anal.*, 41.)

(18) ROSENFELD, H. (1958). Contribution to the Discussion on Variations in Classical Technique. *Int. J. Psycho-Anal.*, 39, 238.

(19) Symposium on the Theory of the Therapeutic Results of Psycho-Analysis. (14th I.P.A. Congress, 1936). *Int. J. Psycho-Anal.*, 37.

(20) WAELDER, R. (1958). 'Neurotic Ego Distortion.' Opening Remarks to the Panel Discussion. *Int. J. Psycho-Anal.*, 39.