recognition. It was done by the analyst avoiding even a semblance of being omniscient and over-powerful; on the other hand he demonstrated his willingness to accept the role of a primary object whose chief function is recognizing, and being with, his patient.

The immediate effect of this incident was a considerable lessening of the tension, the patient had a comparatively good week-end, and for quite some time afterwards he was capable of contact and cooperation. I would even say that it initiated – or reinforced – a change for a better atmosphere in the analytic situation, in which it was possible to make some considerable progress.

Chapter 25

The unobtrusive analyst

We finished Chapter 22 with the two forms of regression but left undiscussed the technical problems as to what the analyst can do to avoid, as far as humanly possible, any risk of a malignant regression and assure the development of a benign form. The discussion in the preceding chapter gave us some general directives on how this could be done. The more the analyst's technique and behaviour are suggestive of omniscience and omnipotence, the greater is the danger of a malignant form of regression. On the other hand, the more the analyst can reduce the inequality between his patient and himself, and the more unobtrusive and ordinary he can remain in his patient's eyes, the better are the chances of a benign form of regression.

Thus we have arrived at one of the most important problems of modern analytic technique, which is how much of the two therapeutic agents – interpretation and object relationship – should be used in any one case; when, in what proportion, and in what succession should they be used? This problem is important in every case, but is especially acute in the treatment of a regressed patient when the work has reached the area of the basic fault. Since, as we have found, words have only a limited and uncertain usefulness in these areas, it seems to follow that object relationship is the more important and more reliable therapeutic factor during these periods, while in the states after the patient has emerged from his regression, interpretations will regain their importance.

The question now arises as to what sort of technique the analyst can use to create the object relationship which, in his opinion, is the most suitable for that particular patient; or, in other words, will probably have the best therapeutic effect. The first analyst who experimented with these effects fairly systematically was Ferenczi. Viewed from this angle his 'active technique' and his 'principle of relaxation' were deliberate attempts at creating object relationships

which, in his opinion, were better suited to the needs of some patients than the atmosphere of an analytic setting created according to Freud's classical recommendations. Ferenczi recognized fairly soon that, whatever he tried to do, the result was that his patients became more dependent on him, that is, he became more and more important for them; on the other hand he could not recognize the reasons why this had to happen. Today we may add that his technique, instead of reducing, increased the inequality between the patients and himself, whom they felt to be really omniscient and all-important.

It was fairly early in my career that I realized that keeping to the parameters of classical technique meant accepting strict selection of patients. In my beginner's enthusiasm this was unacceptable, and under Ferenczi's influence I experimented with non-verbal communications; starting with 1932 I reported on my experiments and results in several papers; most of them reprinted in *Primary Love* (Balint, M., 1952). Of course, my techniques and my ways of thinking have undergone considerable change during the years, and though I am fully aware that my present ideas are anything but final, they have again reached a stage at which I can 'organize' them, that is, express them in sufficiently concrete form so that they can be discussed and, above all, criticized.

In my endeavour to overcome the difficulties just mentioned, for some years now I have experimented with a technique that allows the patient to experience a two-person relationship which cannot, need not, and perhaps even must not, be expressed in words, but at times merely by, what is customarily called, 'acting-out' in the analytic situation. I hasten to add that all these non-verbal communications, the acting-out, will of course be worked through after the patient has emerged from this level and reached the Oedipal level again – but not till then.

May I recapitulate here the several trains of thought that led me to these experiments. On many occasions I have found to my annoyance and despair that words cease to be reliable means of communication when the analytic work reaches the areas beyond the Oedipal level. The analyst may try, as hard as he can, to make his interpretations clear and unequivocal; the patient, somehow, always manages to experience them as something utterly different from that which the analyst intended them to be. At this level explanations, arguments,

improved or amended versions, if tried, prove of no avail; the analyst cannot but accept the bitter fact that his words in these areas, instead of clarifying the situation, are often misunderstood, misinterpreted, and tend to increase the confusion of tongues between his patient and himself. Words become, in fact, unreliable and unpredictable.

This clinical observation is so important to my train of thought that I will show it from yet another angle. Words – at these periods – cease to be vehicles for free association; they have become lifeless, repetitious, and stereotyped; they strike one as an old worn-out gramophone record, with the needle running endlessly in the same groove. By the way, this is often equally true about the analyst's interpretations; during these periods they, too, seem to be running endlessly in the same groove. The analyst then discovers to his despair and dismay that, in these periods, there is no point whatever in going on interpreting the patient's verbal communications. At the Oedipal – and even at some of the so-called 'pre-Oedipal' – levels a proper interpretation, which makes a repressed conflict conscious and thereby resolves a resistance or undoes a split, gets the patient's free associations going again; at the level of the basic fault this does not necessarily happen. The interpretation is either experienced as interference, cruelty, unwarranted demand or unfair impingement, as a hostile act, or a sign of affection, or is felt so lifeless, in fact dead, that it has no effect at all.

Another train of thought started with the discovery of the ocnophilic bias of our technique discussed already in the previous chapters (and in 1959, Chapter XII). Nowadays analysts are enjoined to interpret everything that happens in the analytic situation also, or even foremost, in terms of transference, i.e. of object relationship. This otherwise sensible and efficient technique means that we offer ourselves to our patients incessantly as objects to cling to, and interpret anything contrary to clinging as resistance, aggressiveness, narcissism, touchiness, paranoid anxiety, castration fear, and so on. A highly ambivalent and strained atmosphere is created in this way, the patient struggling, prompted by his desire for independence, but finding his way barred at every point by ocnophilic 'transference' interpretations.

The third train of thought originated from my study of 'the silent patient'. Silence, as is more and more recognized, may have many

meanings, each of them requiring different technical handling. Silence may be an arid and frightening emptiness, inimical to life and growth, in which case the patient ought to be got out of it as soon as possible; it may be a friendly exciting expanse, inviting the patient to undertake adventurous journeys into the uncharted lands of his fantasy life, in which case any ocnophilic transference interpretation may be utterly out of place, in fact disturbing; silence may also mean an attempt at re-establishing the harmonious mix-up of primary love that existed between the individual and his environment before the emergence of objects, in which case any interference either by interpretation or in any other way is strictly contra-indicated as it may destroy the harmony by making demands on the patient.

The last train of thought is connected with my ideas about the area of creation, an area of the mind in which there is no external organized object, and any intrustion of such an object by attention-seeking interpretations inevitably destroys for the patient the possibility of creating something out of himself.

It was discussed in Chapter 5 that objects in this area are as yet unorganized, and the process of creation leading to their organization needs, above all, time. This time may be short or very long; but whatever its length, it cannot be influenced from outside. Almost certainly the same will be true about our patients' creations out of their unconscious. This may be one of the reasons why the analyst's usual interpretations are felt by patients regressed to this area as inadmissible; interpretations are indeed whole, 'organized', thoughts or objects whose interactions with the hazy, dreamlike, as yet 'unorganized' contents of the area of creation might cause either havoc or an unnatural, premature, organization.

The outward appearance of all these, widely different, states is a silent patient, seemingly withdrawn from normal analytic work, 'acting-out' instead of associating, or possibly even repeating something instead of recollecting it; and, last but not least, he may also be described as regressing towards some primitive behaviour instead of progressing towards complying with our fundamental rule. All these descriptions – withdrawal, acting-out, repetition instead of remembering, regression – are correct but incomplete and thus may lead to mistaken technical measures.

Thus the technique that I found usually profitable with patients

who regressed to the level of the basic fault or of creation, was to bear with their regression for the time being, without any forceful attempt at intervening with an interpretation. This time may amount only to some minutes, but equally to a more or less long stretch of sessions. As I have mentioned several times, words at these periods have anyhow ceased to be reliable means of communication; the patient's words are no longer vehicles for free associations, they have become lifeless, repetitive, and stereotyped, they do not mean what they seem to say. The standard technical advice is correct in this case too; the analyst's task is to understand what lies behind the patient's words; the problem is only how to communicate this understanding to a regressed patient. My answer is in accepting unreservedly the fact that words have become unreliable and by sincerely giving up, for the time being, any attempt at forcing the patient back to the verbal level. This means abandoning any attempt at 'organizing' the material produced by the patient – it is not the 'right' material anyway – and tolerating it so that it may remain incoherent, nonsensical, unorganized, till the patient – after returning to the Oedipal level of conventional language – will be able to give the analyst the key to understand it.

In other words, the analyst must accept the regression. This means that he must create an environment, a climate, in which he and his patient can tolerate the regression in a mutual experience. This is essential because in these states any outside pressure reinforces the anyhow strong tendency in the patient to develop relationships of inequality between himself and his objects, perpetuating thereby his proneness to regression.

I wish to illustrate what I have just said by repeating from Chapter 21 an episode from an analysis which, at that time, had been going on for about two years. The patient remained silent right from the start of the session for more than thirty minutes; the analyst accepted this and, realizing what possibly was happening, waited without any attempt whatever at interference; in fact, he did not even feel uncomfortable or under pressure to do something. I should add that in this treatment silences had occurred previously on several occasions, and patient and analyst had thus had some training in tolerating them. The silence was eventually broken by the patient starting to sob, relieved, and soon after he was able to speak. He told his analyst that at long last he was able to reach himself; ever

since childhood he had never been left alone, there had always been someone telling him what to do. Some sessions later he reported that during the silence he had all sorts of associations, but rejected each of them as irrelevant, as nothing but an annoying superficial nuisance.

Of course, the silence could easily have been interpreted as resistance, withdrawal, a sign of persecutory fear, inability to cope with depressive anxieties, a symptom of a repetition compulsion, etc.; moreover since the analyst knew his patient fairly well, he could even have interpreted or guessed one or the other topic emerging in the associations and also some of the reasons why the patient felt that particular idea irrelevant and was rejecting it. All these might have been correct interpretations in every respect – except in one: they would have destroyed the silence and the patient would not have been able to 'reach himself', at any rate, not on that occasion. There is one more unintended side-effect of any, however correct, interpretation: it would inevitably reinforce the patient's strong repetition-compulsion, there would again be someone there, telling him what to feel, to think, in fact what to do.

Furthermore, all this happened in an exclusively two-person relationship; the dynamic problem to be dealt with did not have the structure of a conflict for which a 'solution' had to be found. The situation demanded somewhat more skill from the analyst than, say, the understanding of verbal association; by finding a correct answer to the silence, the analyst was running the risk of raising expectations in his patient that this would possibly happen time and again and trigger in this way the development of addiction-like states; another risk was to impress the patient that he has got an analyst so wise and so powerful that he can read his patient's unspoken thoughts and respond to them correctly, the risk of becoming 'omnipotent'; and lastly, words would have been unreliable in this situation, more likely than not they would have forced the patient prematurely into the Oedipal area and created further obstacles to the therapeutic work instead of removing some. Of course, all these are characteristic signs that the analytic work has reached the area of the basic fault.

The right technique, as long as the patient is regressed to this level, is to accept 'acting-out' in the analytic situation as valid means of communication without any attempt at speedily 'organizing' it

by interpretations. Emphatically, this does not mean that in these periods the analyst's role becomes negligible or is restricted to sympathetic passivity; on the contrary, his presence is most important, not only in that he must be felt to be present but must be all the time at the right distance – neither so far that the patient might feel lost or abandoned, nor so close that the patient might feel encumbered and unfree – in fact, at a distance that corresponds to the patient's actual need; in general the analyst must know what are his patient's needs, why they are as they are, and why they fluctuate and change.

From another angle, the technical problem is how to offer 'something' to the patient which might function as a primary object, or at any rate as a suitable substitute for it, or still in other words, on to which he can project his primary love.

Should this 'something' be (a) the analyst himself (the analyst who undertakes to treat a regression), or (b) the therapeutic situation? The question is which of these two is the more likely to achieve sufficient harmony with the patient so that there may be only minimal clash of interest between the patient and one available object in the present. On the whole, it is safer if the patient can use the therapeutic situation as a substitute, if for no other reason, because it diminishes the risk of the analyst becoming a most important, omniscient, and omnipotent object.

This offering to the patient a 'primary object', of course, is not tantamount to giving primary love; in any case mothers do not *give* it either. What they do is to behave truly as primary objects, that is, to offer themselves as primary objects to be cathected by primary love. This difference between 'giving primary love' and 'offering oneself to be cathected by primary love' may be of fundamental importance for our technique not only with regressed patients, but also with a number of difficult treatment situations.

To describe the same role from a different angle, i.e. using different 'words': the analyst must function during these periods as a provider of time and of milieu. This does not mean that he is under obligation to compensate for the patient's early privations and give more care, love, affection than the patient's parents have given originally (and even if he tried, he would almost certainly fail). What the analyst must provide – and, if at all possible, during the regular sessions only – is sufficient time free from extrinsic temptations, stimuli, and

demands, including those originating from himself (the analyst). The aim is that the patient should be able to find himself, to accept himself, and to get on with himself, knowing all the time that there is a scar in himself, his basic fault, which cannot be 'analysed' out of existence; moreover, he must be allowed to discover *his* way to the world of objects – and not be shown the 'right' way by some profound or correct interpretation. If this can be done, the patient will not feel that the objects impinge on, and oppress, him. It is only to this extent that the analyst should provide a better, more 'understanding' environment, but in no other way, in particular not in the form of more care, love, attention, gratification, or protection. Perhaps it ought to be stressed that considerations of this kind may serve as criteria for deciding whether a certain 'craving' or 'need' should be satisfied, or recognized but left unsatisfied.

The guiding principle during these periods is to avoid any interference not absolutely necessary; interpretations particularly should be scrutinized most meticulously, since they are felt more often than not as unwarranted demand, attack, criticism, seduction, or stimulation; they should be given only if the analyst is certain that the patient *needs* them, for at such times *not giving* them would be felt as unwarranted demand or stimulation. From this angle, what I have called the dangers of ocnophilic interpretations may be understood better; though the patient is in need of an environment, of a world of objects, such objects – foremost among them the analyst – must not be felt as in any way demanding, interfering, intruding, as this would reinforce the old oppressive inequality between subject and object.

I hope this clinical description will help the reader to understand why so many analysts have quite so many different terms to describe it. Some of these terms were enumerated at the end of Chapter 24. All of them had the following features in common: there was the suggestion that no oppressive or demanding object should be present; that the environment should be quiet, peaceful, safe, and unobtrusive; that it should be there and that it should be favourable to the subject, but that the subject should be in no way obliged to take notice, to acknowledge, or to be concerned about it. Once again, these common features are the exact characteristics of what I called primary objects or primary substance.

To provide this sort of object or environment is certainly an

important part of the therapeutic task. Clearly, it is only a part, not the whole of the task. Apart from being a 'need-recognizing' and perhaps even a 'need-satisfying' object, the analyst must be also a 'need-understanding' object who, in addition, must be able to communicate his understanding to his patient.