Some Implications of Conducting Psychoanalysis as a Talking Cure*

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Hyman Spotnitz’s Modern Psychoanalytic approach, through which psychoanalysis is conducted as a “talking cure,” has profoundly influenced my understanding of how to function therapeutically with patients. Ultimately patients are helped to address and verbalize whatever is on their minds, including the full range of what they experience vis-à-vis the analyst and the analysis, especially experiences of negative impact. To this end, inquiry is favored over interpretation. Patients with implosive defenses are especially resistant to experiencing the therapist as the agent of fault—as the caregiving object who fails and disappoints. Instead, anger and hate are turned against the self. When such a patient feels safe enough to place the analyst in the position of “the object not protected,” the angry and hateful feelings that are unleashed may severely test the analyst’s emotional resilience. Management of such “bad-analyst-feelings,” with clinical examples, is discussed. Also discussed are how a patient’s transference predispositions are dealt with in the Modern Psychoanalytic approach; the use of the couch and how it favors an analysis that is conducted as a talking cure; and the problematic consequences that might ensue from the analyst’s self-disclosure.

In 1968, about three years after completing my training at the William Alanson White Institute, I entered analysis with Dr. Hyman Spotnitz. This experience profoundly influenced my understanding of how to function therapeutically with my patients, and I have assimilated into the core of my essential interpersonal/object relational framework certain key features of Spotnitz’s Modern Psychoanalytic approach.

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Spotnitz, a psychiatrist trained in the classical Freudian tradition, nevertheless introduced some radical departures from classical Freudian concepts of theory and practice. He gave the name Modern Psychoanalysis to this revised body of psychoanalytic understanding. His revisions, all in the service of facilitating the therapeutic process, emerged from a rare clinical intuition in combination with an essentially empirical orientation to the practice of psychoanalysis.

It was in the course of applying psychoanalytic method to the treatment of schizophrenic patients that Spotnitz began to depart from the conventional Freudian perspective. In his book Modern Psychoanalysis of the Schizophrenic Patient (Spotnitz, 1985), he challenges Freud’s assumption that schizophrenics cannot be engaged in an analytic process because their libido is locked into the ego in such a way as to render them incapable of making a positive transference to the analyst—which would be necessary for analysis to take place. Spotnitz understands the main basis of psychopathology in schizophrenia to be the problem of imploded murderous aggression. The primary task, therefore, in treating schizophrenic patients analytically is to work not with resistances to the liberation of object libido but, very gradually, with resistances to experiencing and putting into words destructive aggression, which is imploded and directed against the mind and the self and which causes those patients to turn away from reality and generates psychotic experience. The problem in treating schizophrenics, in other words, is not in accessing the positive transference, but, rather, in accessing the negative transference. The successful treatment of a schizophrenic patient requires neither that the patient be capable of a positive transference nor be able to engage in a treatment alliance. For analysis to take place, the patient needs only to be capable of tolerating the presence of the analyst and be able to cooperate with the analyst’s request that he talk.

For purposes of tension regulation, the patient is usually seen no more than once a week and is asked to talk from the couch.

One of the main tasks of the analyst is to enable the patient, very gradually, to access and put into words negative thoughts and feelings vis-à-vis the treatment situation and the analyst. Ultimately this verbalization can escalate into anger and hate. Given that the
analyzer can tolerate the emotionally difficult experience of serving as the target of such object-directed anger and hate, and given that he has learned how to use counterbalancing, limit-setting, nonretaliatory aggression when it may be necessary to do so, the patient is likely to evince a lessening of psychotic behavior and experience.

Much of what Spotnitz discovered in the course of working with schizophrenics is applicable to the wider population of patients that we treat psychoanalytically. Although Spotnitz does not explicitly say so, an essential feature of Modern Psychoanalysis is that the practice of psychoanalysis is a trial-and-error project. For example, I once consulted him about a disagreement that had developed between myself and the two other members of a peer supervision group regarding an intervention I had used with one of my patients. After recounting the discussion, I asked Spotnitz who he thought was right regarding what I had said to my patient. He answered, “How do I know who was right? If your patient reports to you that she was saved from suicide by her two best friends, then you can conclude that your intervention was wrong.”

As obviously sensible as his response was, it was at variance with my previous experience regarding how the merits of interventions were addressed in discussions with supervisors and colleagues. Those interventions would be intelligently discussed, in the absence of an overriding wait-and-see attitude, which I now routinely apply, both to my own work and to that presented to me in supervision.

My understanding of the therapeutics of my experience with Spotnitz has been enhanced by my experience in two previous analyses, which offered me a basis for comparison. I achieved considerable emotional growth in each of these analyses, and I continue to have a high regard for each of my first two analysts. I think it is fair to say, however, that, by comparison, my analysis with Spotnitz constituted a transformational experience. This despite my never having had individual sessions at a frequency greater than once a week. After about two years, I added a weekly therapy group, and, some years later, a supervision group that met every other week. The four years of my first analysis was conducted at a frequency of two individual sessions and one group session per week. The five years with my training analyst was conducted three times per week.

I was, to begin with, skeptical about having sessions only once a week. Once-weekly sessions fell short of the minimum standard of three times a week that would qualify as a bona fide psychoanalysis at the White Institute. I was somewhat reassured by my memory of Erich Fromm's reply to my question regarding what he thought the minimal frequency for psychoanalysis should be. He said, “I analyze people once a week.” Fromm thought that the greater the frequency, the lazier both patient and analyst would become. He thought the sine qua non of three to five times a week was a convention, the main function of which was to authenticate the analyst's identity as a bona fide psychoanalyst within his respective psychoanalytic community. He thought that frequency had nothing to do with the therapeutics of psychoanalysis.

For Spotnitz, the issue of frequency is considerably more complex—it is linked to what might prove to be optimal for a given patient at a given phase of the treatment. A higher frequency of sessions may prove to be worse for certain patients. For the purpose of tension regulation in the treatment of both schizophrenic and borderline patients, Spotnitz recommends a frequency of no greater than once weekly.

In the case of a borderline patient that I discussed in an earlier paper (Epstein, 1979), the optimal frequency turned out to be once every three weeks. When he saw me more often, he was driven by intense destructive envy to wreck the therapy by engaging in dangerously self-destructive behaviors.

With a more integrated patient, the frequency is left up to the patient, as compared with the more conventional psychoanalytic frameworks of understanding, in which more is usually thought to be better. There have been patients in my practice who have made steady progress at a frequency of once a week or less. Others have proven to require a frequency of up to four times a week.

It is unfortunate that many psychoanalytic institutes take the position that a minimum frequency of three or more times a week constitutes a necessary condition for analysis to take place. This stricture implies a degraded view of treatment processes that are conducted at a lesser frequency. It would be more constructive, for training purposes, if the issue of optimal frequency were linked to a given patient's therapeutic need. In classes that I have conducted, candidates have presented cases that were unduly stressful for both patient and therapist because the training requirement of three times per week proved to be too stimulating and therefore destabilizing for the patient. I no longer have to be working at a given frequency to believe that the patient and I are engaged in a viable psychoanalytic process.
To continue my comparison of my analyses, each of the first two analyses was conducted with me sitting up. The setting was informal and friendly. Each analyst called me by my first name. My first analyst would have preferred to have me call her by her first name, but I was more comfortable addressing her as “Doctor.” I was, however, more comfortable by calling my second analyst by his first name.

Spotnitz called all his patients by their last names except in the group settings, where he used first names. From what I could tell, none of his patients called him anything but Dr. Spotnitz, except for the occasional patient who chose to challenge this formality. Spotnitz's setting lacked the qualities of mutuality and collaboration, which were often present in the two previous settings.

On entering analysis, I acceded to his request that I talk from the couch, with him sitting behind me. I was told that my only task was to talk, to put into words whatever thoughts and feelings were on my mind. I was thus initiated into the experience of participating in analysis as a talking cure. Spotnitz's silent, unseen presence gave rise to a heightened awareness of my immediate experience of the session itself, much more than in either of my previous analyses. It was easy for me to address my ongoing thoughts and feelings and put them into words, including my misgivings about the quality of what I was reporting. At times, it felt superficial and repetitious. I wondered about the impact I was making on Spotnitz. At times I worried that I was putting him to sleep.

I would ask, “Are you sleeping?” He would answer, “What makes you ask?”

“Your silence. I don't know whether you are listening, or what kind of judgments you are making about what I have been saying. I would like you to comment on what I have been saying.”

He answered, “You are being cooperative. You seem to be saying all your thoughts and feelings, including your concerns as to whether they are good enough.”

“Are they good enough?”

“They may be not good enough for you, but they are good enough for me.”

He would interrupt his silences, usually to question me further about what I was talking about: “How did you feel when she said that?”

Whenever I indicated that I had unwanted feelings, he would ask why I did not want to feel them. One of the main aims of Modern Psychoanalytic inquiry is to enable the patient to access and put into words unwanted emotional experience and to explore further the possible consequences of bearing such experience in consciousness. I feel confident that this type of inquiry helps to increase a patient's emotional resiliency.

Gradually, as I became less self-conscious about the quality of my productions, I also became aware of negative thoughts and feelings vis-à-vis Spotnitz. Here is an example of the way he facilitated my freedom to say everything to him:

In one session, I got up the courage to tell him about some negative thoughts and feelings that were making a rather unwelcome intrusion into my awareness. I said something like, “This is difficult for me to say to you, but lately I have been having some rather uncomplimentary thoughts and feelings about you.”

He asked, “To what uncomplimentary thoughts and feelings are you referring?”

I said, “More often than not, I have been finding many of the things that you have been saying to be banal and predictable, and I have been feeling somewhat contemptuous. I really hate having to tell you this.”

“What is your objection to telling an inferior guy what you really think of him?”

Most important about the whole process is that, gradually, with his help, I felt increasingly freed to put all this into words with a
minimal sense of accompanying risk. In Winnicott's (1968) terms, Spotnitz enabled me to put him in the position of “the object not protected.” Retrospectively, I can think of nothing that I spared him in the way of negative feedback.

With regard to my two previous analysts, in retrospect, I can think of many critical thoughts and feelings from which I protected them. Later I shall provide a striking example of this. During those previous analyses, such experiences of negative impact either were relegated to the sector of selective inattention or, when in the forefront of my mind, were simply withheld. The main reason, I believe, was that the respective frameworks of psychoanalytic understanding subscribed to by each of these analysts did not place a high value on enabling a patient to access and communicate experiences of negative impact vis-à-vis the analyst. Had I been able to communicate some of my critical thoughts and feelings, I think those analysts might have dealt with them therapeutically, but it was not possible for me to give up protecting my analysts in the absence of

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their establishing the conditions that would facilitate my doing so. (Later in this essay I provide an example of how I did this for a patient of mine.)

This brings me to a discussion of one of Spotnitz's most radical contributions, namely, his recommendation that analysis be conducted as a “talking cure.”

“Talking cure” means that the analyst should, mainly, be working to resolve the patient's resistances to addressing what is on his mind and putting it into words. This approach is at odds with the classical, interpersonal, and relational perspectives in that all three favor working with resistances to understanding. In the Modern Psychoanalytic approach, understanding and insight emerge from what the patient is progressively enabled to put into words. Ultimately the patient is helped to address and verbalize the full range of what he experiences vis-à-vis the analyst and the analytic situation, especially his experiences of negative impact. Spot-nitz often would say that the main purpose of his interventions was to enable the patient to say more. To this end, the Modern Psychoanalytic approach favors inquiry over interpretation.

Spotnitz's view of resistances and defenses matches Sullivan’s (1940) view of “security operations,” namely, that they protect the psyche from the awareness of experience that is unwanted or, possibly, unbearable. In the Modern Psychoanalytic approach, resistances and are worked with patiently and gradually, to the point that the patient no longer has need of them. Questions, usually simple ones, that attempt to take into account a patient's tolerance for impingement, are asked with the aim of enabling the patient to say more about what he has been talking about; or, if he has been silent, he might be asked, “How come you are not talking?”

A colleague of mine, Murray Sherman (1983), contrasted the classical and Modern approaches as follows: “Modern Analysis is significantly a mode of investigation; Classical methodology centers mainly upon explanation” (p. 182). Interpersonal and relational approaches employ both explanation and inquiry.

I want to say a word here about the concept of “unformulated experience,” a concept suggested by Sullivan and creatively elaborated by Donnell Stern (1997). Sullivan put forth the idea that much of what psychoanalytic understanding holds to be unconscious could more accurately be understood to be unformulated rather than unconscious. The concept of unformulated experience has not been assimilated into Modern Psychoanalytic understanding. Yet the Modern Psychoanalytic method of inquiry enables the patient, progressively, throughout the analysis, to raise the level of unformulated experience to the level of formulated experience in ways that deconstruct many of the assumptions that have compromised his capacity to thrive.

This idea was dramatically exemplified in response to a question I posed to a patient who was terrified of flying. I asked, “If I were able to cure you of your fear of flying, might there be any reason that you would not want me to be successful?” She thought for a minute before responding. “Yes,” she said, “because, when I can get myself to stay on the plane, [she was, most often, driven by her anxiety to leave the plane before takeoff] I believe it is my fear that keeps the plane from falling out of the sky and crashing.”

Following her putting that into words, her fear of flying, with no further discussion, became markedly diminished. Had I interpreted what she had formulated in her own words in response to my question, I believe it is unlikely that such an interpretation would have had an equivalent power to bring about change.

I am reminded of the misgivings Winnicott (1968) voiced about his use of interpretations at a later point in his practice. He wrote: “It appalls me to think of how much change I have prevented or delayed in patients … by my personal need to interpret … [Currently] I think I interpret mainly to let the patient know the limits of my understanding. The principle is that it is the patient and only the
patient who has the answers” (pp. 101-102).

The problem with interpretations is that they are often experienced by the patient as unwanted information. Interpretations may be freighted with unwitting countertransference enactments. They may serve defensive needs or be driven by retaliatory impulses. At such times that the analyst is suffering from bad-analyst feelings, he may be driven to interpret out of a need to feel, or show himself to be smart. The patient may sense the analyst's need to have his interpretations validated and may comply by making such false-self adaptations as agreeing with the analyst's interpretations. Or the patient may not recognize the intent of a retaliatory interpretation and accept the feeling of being made to feel wrong or bad. As Ferenzci (1933) noted, interpretations may reenact early patterns of parental mystification. In my own practice, I use interpretations sparingly, usually when the patient requests them or when I think that an interpretation might be assimilated with good effect. I am also prepared to find out that my expectations in this regard were wrong.

Questions, I believe, carry forth processes of demystification, especially questions that heighten a patient's freedom to access and verbalize experiences of negative impact about the analyst and thoughts and feelings regarding the analyst's faults and deficiencies, including whatever suspicions he might have regarding the analyst's motives.

In the frame that I currently establish with my patients, the patient is initiated into the process of analysis as a talking cure, as I was, by being told that his only task in sessions is to talk—not to free associate, just to talk. He is asked to say, to the best of his ability, whatever is on his mind. Before long, he may protest that what is on his mind is not good enough, or repetitious, or not meaningful, or trivial, or boring. He is then told not to judge the value of what is on his mind. He should just say everything and that everything is of equal value to everything else.

My repeated experience with a particular type of transference-counter-transference matrix (Epstein, 1982) has bolstered my confidence in conducting analysis as a talking cure. I am referring to analyses involving patients who can feel comfortable and safe with me only if I permit them to include me within the sphere of their omnipotence. Any expression of my separateness and otherness might be experienced as threatening, even as potentially annihilating. This ego-state, when presented in analysis, has been termed by Spotnitz (1976, 1985), “the narcissistic transference” (see also Margolis, 1978), and by Kohut (1971) as well. Later Kohut (1978) changed this term to “the selfobject transference.” That transference requires me to keep a low profile in session after session, sometimes over a period of many months and sometimes extending into years. I allow myself to be distanced and neutralized, speaking only when the patient, either directly or indirectly, indicates that he or she might need my participation and limiting my communications, mainly, to questions about whether or how I should be participating. At times, I have had to endure a mind-numbing tedium. What I have found to be remarkable is that this apparently nonanalytic level of discourse is typically correlated with progressive improvements in the patient's outside functioning: that is, patients function less symptomatically and more normally.

I have learned from such deadening treatment situations that their therapeutic efficacy should not be judged on the basis of how the treatment feels, either to the patient, or to myself. What matters is that the analysis be accompanied by evidence of progressive improvement in the patient's functioning in his life outside treatment. The patient may not be ready to acknowledge that he is, in fact, dependent on my competence to do good-enough therapy.

Ultimately, the patient may reach the point of feeling that he is not getting anywhere with the way that he has been talking in sessions. He may then be driven to emerge from his narcissistic ego-state. Typically, he signals this emergence by complaining to the analyst about the way he has been talking and blaming himself. At this point the analyst will be in a good position to begin the work of resolving the patient's resistances to becoming engaged in an interpersonal relationship with the analyst. Most important, he can begin the work of resolving the patient's resistances to addressing and putting into words negative thoughts and feelings that he might be having about the analysis and the analyst.

What follows are two interchanges that exemplify this process. They also exemplify Modern Psychoanalytic inquiry and the
emergence of formulated experience. At one point in the session my patient broke out of his narcissistic monologue to exclaim, “Ah shit!”

I responded, “What was that about?”
“I can't stand the way I am talking.”
“What can't you stand about the way you are talking?”
“I can't stand having to say everything in such a precise and deliberate way. It's exhausting!”
“Why do you have to say everything in such a precise and deliberate way?”
“If I am not careful to control everything I say, something will come out of me that will reveal me to be such a despicable person that you will throw me out of therapy.”
“How do you know that I will throw a despicable person out of therapy?”
“I don't know for sure, but I am not ready to take the risk.”

About three months later, I was again jolted fully awake by the exclamation, “Ah shit!”
“What is that about?”
“I can't stand working so hard here. I am laboring to be the perfect patient.”
“What is the perfect patient?”

“Then you might misunderstand me and possibly ruin my therapy. You might even ruin me.”

I have trained myself to assume an attitude of naïve curiosity when I address questions to the patient. I may ask questions to which the answers may seem obvious: as the patient learns to take all my questions seriously and to answer them thoughtfully, the responses often prove to be richly textured and to advance the emergence of formulated experience.

The foregoing interaction occurred at a point when the patient finally had become fed up with his efforts to cure himself. His need for some participation from me broke through the wall he had erected to bar me from the analysis. His responses to my inquiries brought to the level of formulated experience what he might be risking by engaging my participation: he might cause me to throw him out of analysis, and he might cause me to ruin the analysis or ruin him.

Transference and the Modern Psychoanalytic Approach

To begin with, I present my own interpersonal-object-relational perspective on transference. I believe that, if the psychoanalytic situation is to be therapeutically effective, it must activate the patient's pathological transference predispositions so that they can be played out in the interpersonal field of the psychoanalytic interaction. The re-presentation and working-through of such transference predispositions constitute essential conditions for bringing about deep and enduring changes in the pathological internal self-and-object relationships that stunt the patient's emotional growth. It is the analyst's understanding of, and his commitment to, working with the transference that differentiate psychoanalytic process from all other forms of psychotherapy in which the therapist attempts to practice his expertise from a position outside the transference.

Relational psychoanalysis favors an understanding of transference as that which is cocreated by both patient and analyst. This idea corrects Freud's view of transference as being based on a “false connection” and

then projected onto the analyst as a blank screen. When this is then interpreted to the patient with the aim of correcting his distortion of reality, the patient's experience is often that of feeling that his reality is being invalidated rather than corrected.

Modern Psychoanalytic understanding does not encompass the concept that transference is cocreated; but in the Modern
Psychoanalytic approach transference manifestations are seldom, if ever, interpreted or addressed as such. They are addressed as if they are understood to be subjective3 reactions of the patient that have been in some way activated by the analyst. In my own practice, a patient might experience me as emphatically failing him or mistreating him in a way that might strike me as transferential. It is not important for me to decide if this is true. What is important is that I take the patient's negative attributions seriously and, by exploring them fully, enable him to express all his thoughts and feelings regarding his experience of negative impact, including his interpretations as to what I have been up to and why. I regard what I hear from the patient as feedback, which leads me to scan my countertransference for possible negative feelings toward the patient that I may have not fully owned. At times, patients have correctly identified unwitting enactments on my part.

This is not to say that a patient is not helped to understand how his feelings toward the analyst might replicate feelings he frequently had toward one or another of the persons with whom he grew up. If I want to call attention to a possible connection between a patient's negative experience of me in my role as a caregiver and one of his parents, I might say something like, “It seems as though I have been no more attuned to you in this regard than your mother was.” In other words, I am careful not to invalidate his experience of me as the agent of fault by implying that it is based on a “false connection.”

An important feature of the analytic attitude in the Modern Psychoanalytic setting is to maintain an ongoing alertness for indications that the patient may be evincing an unwitting negative therapeutic reaction. While Sullivan recommended attending closely to a patient's gradient of anxiety for fluctuations in self-esteem and adjusting one's technique accordingly,


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Spotnitz recommends attending to what I would term the “gradient of negative impact,” including being alert to, and investigating, signs or symptoms of regressive functioning in the patient's life outside sessions. The patient might be asked, for instance, “What do you think is going on in your analysis lately that might be giving you headaches?—or making you late for sessions?—or making you more accident-prone?—or inclining you more to use alcohol?”

At those times during a session when I am experiencing difficulties with my cognition, attention, or concentration while listening to a patient, I might wait for an appropriate moment to ask, “Is there anything else that might be going on in your mind while you are talking?” The patient may be taken aback by this question and want to know what made me ask it. He is usually accepting of my response, which is something like, “It just occurred to me to ask.” More often than not, the patient is enabled to contact and put into words some ongoing negative thoughts and feelings regarding me or his experience of the analysis that he has been dealing with by using selective inattention.

Spotnitz emphasizes working with resistances to the negative transference because he understands the implosion of aggression to be a factor in all psychopathology, not only in schizophrenia. A major task of the analyst, in any given analysis, is to enable the patient, progressively, to address his experience of the analyst as the agent of fault—as the caregiving object who fails and disappoints—and to put such experience into words. Resistances to faulting the analyst are deeply entrenched in those patients who present implosive defenses. Such patients, very early in life, learned to protect their caregivers from any expression of feelings of anger, hate, and disappointment and to protect themselves, as well, from retaliation. They learned to use the self, the mind, or the body as the target of their own aggression, the result being lifelong tendencies toward self-attack, self-hatred, self-abandonment, depression, physical illness, and, possibly, suicide or psychosis.

This complex of security operations, by which an awareness of negative emotional experience of the other is blighted and by which anger and hate are imploded constitutes a powerful and sometimes lethal dynamism that persists in being intractable to therapeutic influence. The persecutory self-and-object relationships that populate the patient's internal world are locked to the psyche in such a way as to constitute a massive resistance to engaging the analyst as anything but a good or neutral transference object. The analyst is thereby effectively excluded as a transference object that

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might be used as either the embodiment of the patient's internal persecutory objects or the embodiment of the bad, victimized, and persecuted self.
Spotnitz has devised a strategy for resolving resistances to the negative transference: the analyst positions himself in relation to the patient as taking responsibility for the progress of the treatment. It is up to the analyst, in other words, to make the analysis work. At any point that a patient is inclined, for instance, to blame himself for what feels like a lack of progress, he is reminded that his only task is to say what is on his mind: “It is my job to make the treatment work. If it isn’t working, what occurs to you that I might be doing or not doing that might be contributing to this?”

The following interaction, occurring very early in an analysis, exemplifies how I employed this strategy:

The patient, whom I shall call Ms. D, was an intellectually gifted 40-year-old woman, who had terminated a long-term analysis three years prior to consulting me. She suffered from depressive mood swings. On three occasions over the prior 15 years she came dangerously close to taking her life. Vague about what might have precipitated her suicide attempts, she remembered only that she had been driven by intense self-hatred. She was able to connect the last suicide attempt with the memory of feeling that her analyst had come to find her insufferably boring.

Very early in her life Ms. D developed a pattern of protecting both parents by keeping her feelings of being aggrieved to herself and by turning anger, hate, and contempt against herself. Thus she protected herself, as well, from retaliation. On the basis of this information, it became clear to me that if the analysis was to be successful in eroding Ms. D's implosive defenses, one of my main tasks was to enable her to feel safe enough to contact and put into words muted, selectively inattended, and dissociated experiences of negative impact vis-à-vis myself in my role as a caregiver.

Ms. D entered analysis with me reluctantly. She said that she anticipated the shame and humiliation she would have to experience in the course of revealing her weaknesses to me, and, having failed in treatment with a high-profile analyst, she had little confidence that she would do any better with me. Her matter-of-fact exoneration of her previous analyst as having in any way contributed to the failure of the treatment, and her belief that she alone was at fault, provided me with an opportunity to challenge these assumptions and introduce myself for her consideration as the agent of fault. I said, “The failure of your last analysis was your analyst's failure,

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4 See Epstein (1999) for a more complete presentation of this case.

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and, if this analysis should fail, it will be my failure. It will be up to me to figure out how to make the analysis succeed.” Far from being reassured, Ms. D appeared to be taken aback and somewhat apprehensive.

I asked, “What are your thoughts and feelings in response to what I just said?”

“I know I should feel reassured to have you take responsibility for making the treatment work, but I don't,” she answered.

She was, at first, vague about her misgivings because of her anxiety about having unwelcome thoughts and feelings about me. Haltingly, in response to my persistent inquiries, she offered the following: that I struck her as

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suicide attempts, she remembered only that she had

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The precursors to this complex of implosive defenses usually become clear in analysis. In most cases, the patient was very early recruited to serve as a selfobject by one or both parents and was used to meet the parental object's need for tension regulation and need satisfaction, sometimes serving as the target of projections, bad feelings, or feelings of badness, sometimes serving to support the parent's need for feelings of goodness by never addressing the parent as the object of fault. For such patients, the restoration of emotional health depends greatly on the resolution of resistances to recognizing and verbalizing experiences of negative impact in relation to the analyst or the analytic situation at such points that those patients may experience disillusionment or disappointment with the treatment (see Winnicott's, 1968, concept of object usage). Like Winnicott, Spotnitz understands a main function of the analyst to be that of a "maturational agent." The analyst must, in other words, provide the patient with experiences that will be corrective for parental failures of adaptation to the patient's particular constellation of maturational and emotional needs in infancy and early childhood. As the patient comes to feel safe enough to put his negative thoughts and feeling into words, he may become increasingly sensitized to all manner of unwitting misattune-ments committed by the analyst. The following words from Winnicott (1955-1956) are relevant here:

_A treatment of the kind I am describing has gone a long way when the patient is able to take an example of original failure and be angry about it._...
The patient makes use of the analyst's failures. ... a very small error of judgment can produce a big effect. The clue is that the analyst's failure is being used and must be treated as a past failure, one that the patient can perceive and encompass, and be angry about now. If he (the analyst) defends himself, the patient misses the opportunity to be angry about a past failure just when anger was becoming possible for the first time [p. 298].

The angry and hateful feelings that are unleashed in the course of resolving the patient's implosive defenses are likely to severely test the analyst's emotional resilience. He may have to endure “bad-analyst feelings”—feelings of incompetence, feelings of badness and lack of goodness—sometimes for many years (Epstein, 1987, 1999). The success of the analysis depends greatly on the analyst's capability for containing and processing his induced negative countertransference experience in the best interest of the therapy. In Winnicott's (1968) terms, this means not retaliating and, I would add, not in any way abandoning the patient.

In the case of Ms. D, the patient to whom I introduced myself as the agent of fault, when she reached the point of feeling safe enough to place me in the position of “the object not protected,” there followed several years during which her experience of my negative impact became the main focus of the analysis. She became extremely sensitive to what she experienced as my misattunements and empathic failures. She would fault me for not saying anything, for saying the wrong thing, for saying something inadequate and unhelpful. I would be faulted for my tones of speech—for sounding critical or indifferent. The many memories she recovered of similar misattunment and neglect by her parents did nothing to temper her view of me as a caregiver who repeatedly failed her in one way or another. Instead she discovered more and more about how my deficiencies matched those of her parents.

Gradually her negative view of me expanded to include the possibility that I might be too narcissistic to be adequately responsive to her. That my deficiencies so closely paralleled those of her narcissistic mother frightened her. She felt hopeless and despairing, all the more so because she felt stuck with an analyst in whom she was losing confidence.

I, too, felt trapped with her in this analysis, which was fraught with bad and painful feelings. I often came close to feeling like a truly bad analyst for her. I sometimes entertained the wish that she would leave so that her doing so would spare us both further anguish. I should make clear that the bad feelings induced in me by this patient occurred in an emotional context that always felt completely authentic. She was truly upset and suffered intensely in response to what she experienced as my empathic failures.

Yet, notwithstanding her repeated experiences of feeling traumatized in the analysis, she was progressing in all areas of functioning in her outside life. She became more aware of her own needs, feelings, and desires, and she felt more entitled to assert her right to have them respected. Her depression and despair were linked entirely to her experience of my deficiencies as a caregiver. Although she was not yet ready to acknowledge, either to me or to herself, that the analysis was in any important way helpful to her, I believe it was her awareness of her progress in her outside life that caused her to persist in treatment. She would blame this on her “masochism.” I thought of her perseverance as an expression of her courage. The fact of her progress provided me with some hope that we were working through a transference neurosis.

This movement, however, did not mitigate my bad-analyst feelings. I needed to work hard with my countertransference. I relied on what I would term “rescuing thoughts.” It helps me to bear the bad feelings that are induced in me when I am being addressed as a bad object if I conceptualize my emotional vulnerability as a re-presentation of the patient's parents' vulnerability, which they failed to process in the patient's best interest. It helps me to curtail my defensiveness in the face of what feels like the patient's distortions or misreadings of my behavior, attitude, and intentions if I remind myself that, by investigating, rather than interpreting, such attributions, I am helping the patient develop a sense of agency and empowerment vis-à-vis the persecutory objects of both her external and her internal self-and-object worlds. I also think of my role and function in Winnicott's (1968) terms, as the caregiving object that receives aggression, but does not retaliate. In such an analysis as I have been describing, I may have to bring such “rescuing thoughts” to mind with some frequency.

In one session, I initiated an exchange that turned out to validate my confidence in this analysis as a talking cure. Ms. D had again been equating my narcissism with that of her mother. I asked her, “Is it good for you to continue working with an analyst who is no better than your mother?”

After a thoughtful silence, she said, “There is one important difference between you and my mother. I can tell you about it.”

This exchange constituted a turning point in the analysis. Soon after, Ms. D began a session by saying that she realized that she had been reliving with me the experience of the devastating impact of her mother's
narcissism. From this point on, she became much less focused on either my deficiencies or her own. The shadow of badness and no-goodness that had issued from her internal self-and-object world lifted from both of us.

The Couch in the Talking Cure

I think that talking from the couch favors an analysis that is conducted as a talking cure. First, I should say that I think I function better as an analyst when I am free of the impingement of being looked at by my patients. I find myself in a better position to process my thoughts and feelings and to inhibit impulses to act out my countertransference.

More important, the advantage of talking from the couch quickly became apparent in my own analysis with Spotnitz and in the analyses of those patients in my practice who accepted my invitation to shift from the chair to the couch. My patterns of communication and those of my patients changed in a way that made it increasingly clear that talking from the couch is likely to limit a patient's use of selective inattention to withhold and thereby deprive the analysis of many ongoing thoughts, feelings, and perceptions.

Most patients sitting up and looking at the analyst will likely be stimulated by perceptions of his appearance, attitude, and behavior, accompanied by thoughts, feelings, and self-referential interpretations about the meaning of such perceptions. Yet no part of this experience may reach the center of consciousness in a way that would promote its formulation in words that can be communicated. For example, interpretations concerning my reactions as approving or disapproving may unwittingly influence the value a patient places on what it is he is talking about and may be likely to influence, as well, what he next talks about and how he presents it.

On the couch, though, with the reduction of visual cues, both the patient and the analyst are more likely to become aware of the patient's anxieties, needs, and feelings regarding the analyst and their ongoing relationship. The patient is in a better position to register this experience at the center of consciousness and put it into words, and the analyst is in a better position to sense that something might be going on about which he might want to inquire. Thus, much material that may be locked into silently and unwittingly enacted byplay while the patient is sitting up can be liberated and included in the analysis when the patient is lying down.

In working with borderline patients and schizophrenic patients, contrary to preconceptions about how destabilizing the use of the couch might be for patients with such massive ego deficits, in practice the reverse, more often than not, proves to be the case. Spotnitz (1985) observed that borderline and schizophrenic patients are more likely to be destabilized because they are emotionally overstimulated when sitting up and looking at the analyst. He found that on the couch such patients can be made to feel more comfortable. Aggressive impulses can become more manageable and can be put into words, approximating rational discourse. They are less likely to be enacted and are less likely to be imploded, resulting in the psyche becoming fragmented and overwhelmed by psychotic experience.

It is important to provide an optimum balance of stimulation and frustration. Sitting up and looking at the analyst may result in external overstimulation, which the analyst cannot control. Lying down and not seeing the analyst can result in overstimulation from within if the patient is subjected to too much sensory deprivation. The analyst, however, usually can control this internal overstimulation by keeping sufficiently in contact with the patient—by, for instance, interrupting silences and asking the patient why he is not talking.

Self-Disclosure and the Talking Cure

In an analysis conducted as a talking cure, the main purpose of any given intervention is to facilitate the patient's talking—to enable him to address his experience and put it into words with a decreasing sense of accompanying risk. The question is, with regard to any given instance of the analyst's self-disclosure, does it prove to be enabling or disabling in this regard?

Perhaps beginning with Ferenczi (1933), analysts of both the interpersonal and the relational schools increasingly have come to understand the analytic interaction to be one of mutual influence. Accordingly, one of the analyst's main tasks is to own and process his countertransference so as to minimize its possible negative consequences for the treatment and to enable the patient to process the impact that both the analyst and his method might be having on him. Inevitably there will be countertransference-driven enactments and other treatment errors, which, if not fully owned and repaired by the analyst, can seriously disadvantage the treatment process. I have been consulted by a number of patients who left treatment.
because their analysts failed them in this way. Ferenczi recommended that an analyst fully self-disclose his treatment errors to safeguard the patient from becoming subjected to a repetition of being enjoined from seeing and speaking of the analyst's failings as he was enjoined from seeing and speaking of the failings of his parents. Ferenczi was concerned about the danger of the analyst's falling into the pitfall of reenacting parental patterns of mystification. This was probably what he understood had happened in his analysis with Freud. The question is, in any given interaction what might be the impact of the analyst's direct self-disclosure on processes of mystification and demystification?

There is a problem in attempting to demystify ourselves by too early and too freely admitting our treatment errors. By being too generously self-disclosing instead of enabling our patients to recognize or discover our treatment errors, we may be unwittingly engaged in a subtle process of mystifying the patients; by telling them what we think they should know about us, we may be limiting their possibilities for imagining or perceiving what we unconsciously may not want them to know about us. By “being good” to our patients in this way, we might unwittingly interfere, as well, with their accessing unwanted feelings of disappointment, anger, and hate and thereby prevent them from using us as analytic object. And we may be unknowingly protecting ourselves from the difficult emotional experience of being the object of such feelings.

Had I confessed my failings to Ms. D instead of letting her discover them, I doubt that she would have been able to put me in the position of “the object not protected” to the extent of so ruthlessly faulting me, and I would have never had the satisfaction of knowing that I had contributed to the resolution of her implosive defenses.

Some Negative Consequences of the Analyst's Disclosing Experiences of Negative Impact Induced by the Patient

In a panel discussion on self-disclosure (Epstein, 1995), I reported on an experience of negative impact that I had had in response to my analyst's self-disclosure. Actually, at the time that the interaction took place, I did not register it in consciousness as an experience of negative impact. I had been in this analysis for about three years and was applying for admission to the White Institute for psychoanalytic training. My analyst was a training analyst at another institute, to which it did not make sense for me to apply because its time requirements were practically impossible for me to meet. The White Institute, in any case, was my institute of choice.

During one session, I was discussing some of my concerns about my upcoming admission interviews, oblivious to the implications for my current analysis should I be accepted for training at the White Institute and oblivious of any impact that I might be having on my analyst. My analyst told me that I was making her feel disregarded and perhaps even held in contempt. I liked her, and I felt that she liked me and truly cared about me. I immediately understood that she was confronting me with my in-sensitivity to my interpersonal impact. My self-centeredness in this regard was not news to me. I remember thinking appreciative thoughts, something like, “This is a good intervention for me.” On another level, I felt very bad about myself and very guilty for having slighted her. I expressed only my positive understanding of what she intended, however, and did not tell her of my bad feelings, which I relegated to the sector of selective inattention. I think I understood that I deserved those bad feelings as just punishment for having been so insensitive. It never occurred to me to fault my analyst. Instead I made her right. I dealt with my guilt by managing to delay the date of my leaving her to begin working with my White Institute training analyst.

The impact of my analyst's self disclosure was to engage me in making false-self adaptations to her need to have me take her feelings into account. It is possible that the contempt I made her feel was truly mine, but it was dissociated. Her intervention did nothing to facilitate its entry into the analytic relationship. I do not mean that the intervention was necessarily wrong. The negative impact that this instance of self-disclosure had on me could have been turned to a good therapeutic effect had my analyst been interested in enabling me to put into words all my thoughts and feelings in response to her intervention and had she been interested in discovering its possible destructive consequences.

Particularly striking about this experience is that it never reached the level of fully formulated experience until it came to mind while I was preparing for the panel on self-disclosure, some 30 years later. However I rationalized this, I remained in treatment with my analyst for almost a full year (most of my first year at White) before leaving her to begin working with my White Institute training analyst. Later it became clear to me that I had stayed this long only to take care of her.

[5] Self-disclosure is favored by some relational clinicians. See Greenberg (2001) for a critique of some recommended practices.
Whether or not patient and analysis can recover from a dissociated or selectively inattended experience of negative impact may depend on whether or not the patient can contact this negative experience, formulate it, and put it into words. Doing so, in turn, will very much depend on whether or not the analyst has made the patient feel safe enough to say everything. The question is, does the analyst who favors making self-disclosures want to hear everything and feel everything that hearing everything might make him feel?

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