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BERNFELD'S "THE FACTS OF OBSERVATION IN PSYCHOANALYSIS": A RESPONSE FROM PSYCHOANALYTIC RESEARCH

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In his 1941 article, "The Facts of Observation in Psychoanalysis," Siegfried Bernfeld wrote that observing the sequence of events leading up to and following the patient's confessing a secret is important for psychoanalytic theory. The patient's confessing a secret may follow a comment by the analyst that clears away the obstacles to the patient's confessing by creating an encouraging atmosphere and reducing the patient's shame or distrust. Bernfeld believed that the study of this sequence would be fruitful for the development of psychoanalysis. His article now seems prescient. Members of the San Francisco Psychotherapy Research Group have used formal empirical methods to study Bernfeld's thesis, and we have found strong support for his assumptions.

In his paper, "The Facts of Observation in Psychoanalysis" (1941), Siegfried Bernfeld wrote that observations of the behaviors of the patient leading up to and following a confession of a secret are pertinent to the science of psychoanalysis. Bernfeld suggested that the study of this sequence through research methods would be a useful way of developing the science of psychoanalysis. He described the patient's behavior before, during, and after the confession of a secret as comprising five observable phases:

1. The patient displays his or her usual behavior.
2. The patient behaves as though hiding a secret.
3. The analyst intervenes, thereby clearing the way of obstacles to the patient's confessing the secret.

4. The patient confesses.
5. The patient resumes his or her usual behavior.

Bernfeld illustrated this sequence with an example from everyday life:

> A friend telephones and says he wants urgently to see you. He comes. The conversation starts vividly, but you feel that what he is talking about is not what he came to talk about. To your direct question, he replies unconvincingly that there is no special reason for his calling on you. Thereupon the conversation becomes heavy. By chance you notice that the door of the room is open and automatically you close it. 'By the way', says your friend, 'would it be possible for you to lend me $10.00? But please don't tell anybody' (p. 344).

Bernfeld explained that in "closing the door you created an encouraging atmosphere" (*ibid.*), for you ensured your friend the confidentiality he desired.

In general, Bernfeld continued, the obstacles to confessing are not external but internal, "as when distrust or shame obstructs the confession. Then the removal of the obstacle will not consist in changes of the environment, but in attempts [by the analyst] to induce confidence or to dissipate shame" (p. 345).

Bernfeld used the following example to illustrate the analyst's use of a verbal intervention to reduce the patient's shame so that the patient could make a confession. The patient talks about a party at which Mr. X, a friend of the analyst, is mentioned. The patient's account of the remarks made at the party about Mr. X are obviously incomplete. The analyst assumes that the patient is afraid of being considered a gossip, so he reminds the patient that it is his duty to report things which in ordinary life would be considered gossip. The patient responds by telling the analyst of certain unfriendly gossip about Mr. X which was previously unknown to the analyst.

The examples that Bernfeld gave are of secrets that are conscious or close to consciousness. However, he clearly believed that with the removal of obstacles, not only conscious secrets but also unconscious repressed secrets may emerge, for it is with such secrets that psychoanalysis is mainly concerned.

The Study of Bernfeld's Observations by Formal Empirical Methods

Bernfeld's observations were prescient. Harold Sampson, the San Francisco Psychotherapy Research Group (formerly the Mount Zion Psychotherapy Research Group), and I have been using formal empirical methods to study the sequence of events leading up to and following the patient's confession of a secret (Weiss, et al., 1986; Weiss, 1993a, 1993b).[1] Our findings support Bernfeld's observations and also his suggestion that the detailed understanding of this sequence throws light on the science of psychoanalysis. We found as Bernfeld assumed, that patients feel relieved by the intervention of the analyst that precedes the telling of the secret. It assures the patients that the analyst will not react unfavorably to the confession, thereby helping them to feel safe enough to confess.

This finding, which is consistent with Bernfeld's observations, suggests that patients want to make the confessions as part of working to overcome the sense of shame, guilt, fear, or expectation of external danger that impedes their efforts to seek certain desirable goals. However, they are reluctant to tell their secrets for fear they may endanger themselves. They fear that the analyst will react unfavorably by shaming them, making them feel guilty, punishing them, rejecting them, etc. If the analyst behaves in a way that relieves the patients' shame, guilt, or mistrust, they may feel safe enough to make the confession.

The idea that patients want to confess may be illustrated by Bernfeld's two examples. The man who came to borrow money wanted to make his wish to borrow money known but was

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ashamed to do so until the closing of the door made it safe. The patient who had heard gossip about the analyst's friend wanted to tell the gossip but feared the analyst would look down on him for doing so. He did so, however, after the analyst assured him that it was his duty to tell things that ordinarily would be considered gossip.

Our research emphasizes, even more than does Bernfeld's clinical observation, the patients' wish to confess. We found that in many instances patients, in preparation for telling a secret, work to assure themselves that they may safely tell it. They test the analyst in order to assess in advance how the analyst will react to the secret, hoping to assure themselves that the analyst will not react unfavorably. Our research findings indicate that while testing the analyst, patients feel anxious, for they fear the analyst may fail the test. After the analyst passes the test, patients feel calmer, less defensive, and less anxious, and they continue to feel that way while making the confession.

In our research we have found that patients test the analyst much as one person tests another in everyday life, and that the members of our research group can agree about when patients are testing and what they hope to learn about the analyst by the testing. An example may make the testing process clear.

A patient who wants to be assured of the analyst's interest may test the analyst by threatening to quit treatment. While threatening to quit, the patient is anxious and fears the analyst will permit the ending of treatment. After the analyst passes the patient's test by indicating either through interpretation or through another kind of intervention that the analyst hopes the patient will continue, the patient may feel relieved and become measurably calmer and less anxious. Then, knowing that the analyst does not agree to stopping treatment, the patient may confess that he or she feels undeserving of therapy. In the sequence in which the patient tests the analyst, the series of observable events contains one more step than the sequence Bernfeld described:

1. The patient displays his or her usual behavior.
2. The patient demonstrates conflict about continuing his or her line of thought and is anxious.
3. The patient tests the analyst, continuing to be anxious for fear the analyst will fail the test.
4. The analyst passes the test by an intervention or interpretation.
5. The patient feels safer, becomes calmer, less anxious, defensive, and inhibited, and makes the confession.
6. The patient resumes his or her usual behavior.

Our research also supports the conclusion that the process leading up to the patient's confessing may take place unconsciously. This finding is important, for it supports the hypothesis that patients unconsciously want to confess secrets and unconsciously are able to assess when they may safely do this. Moreover, this finding indicates that the patient exerts considerable control over her or his unconscious mental life. Patients may unconsciously devise and carry out tests of the analyst as part of their working to be assured that it is safe to confess. If they unconsciously decide it is safe, patients may lift their repressions and bring the secret to consciousness.

In this discussion of our findings, I have used Bernfeld's terminology: suppressed or repressed material is called secrets; bringing forth this material is confessing. This terminology captures something important about the analytic process. However, a more general terminology is sometimes preferable. Warded-off material may not always be shameful secrets in the usual sense. For example, a patient may ward off pride or a sense of competence for fear of challenging the analyst, or she or he may ward off a life goal for fear the analyst would disapprove of this goal. An affect such as love for the analyst may be warded off for fear of seducing the analyst or of being rejected by the analyst. Memories of traumatic experiences could be warded off for fear the analyst will not help to master them, and so forth.

Freud's Views

Our findings concerning the patient's unconscious wish to confess secrets and her or his unconscious control over mental life are not consistent with Freud's theory of therapy as presented in the *Papers on Technique* (1911-1915). However, they are consistent with concepts that Freud developed piecemeal in his late writings as part of his ego psychology, which, in my opinion, strongly influenced Bernfeld's thinking. In these, Freud wrote of the unconscious wish for mastery (1920, pp. 32, 35) and of the patient's working unconsciously with the analyst to achieve mastery (1937, p. 235).

Freud also wrote of patients' unconscious control of repressions (1940, p. 199). He stated that patients may keep unconscious mental contents repressed as long as they unconsciously believe they would be threatened by their coming forth. They bring them forth once they unconsciously believe that they may safely do so (*ibid.*) Freud even introduced the idea of unconscious testing. He assumed that before unconsciously carrying out a proposed course of action patients may attempt by "experimental actions" to determine whether they may safely carry it out (*ibid.*).

Since Freud, a number of analysts have expanded on these ideas. Kris (1950, 1951, 1956a, 1956b) wrote about the patient's capacity to bring repressed contents forth without their being interpreted. Sandler and Joffe (1969) wrote about the patient's capacity to regulate repressions in accordance with anticipation not only of danger but also of safety. Rangell (1968, 1969a, 1969b, 1981a, 1981b) and Dewald (1976, 1978) have discussed the role of unconscious testing. Rangell stated that the patient unconsciously tests the analyst, and the analyst may unconsciously fail or pass the patient's tests.

The idea that the patient may assess the environment unconsciously and act on this assessment is supported by cognitive research, which indicates that a person can unconsciously make such assessments and act on them much more rapidly and efficiently than he or she does consciously (Dorpat, 1992; Lewicki, et al., 1992).

Crying at the Happy Ending

Before presenting a more detailed description of our research, I shall illustrate the concept of unconscious control by an everyday example. The following example, which is an instance of crying at the happy ending (Weiss, 1952, 1993a; Weiss, et al., 1986), is similar to Bernfeld's, in that an external change makes it safe for a person to experience something that was suppressed.

A mother has lost her child and is searching for him. While searching, she suppresses or lightly represses her sadness. To fully experience her sadness would hamper her in her search. When she finally finds her child, she bursts into tears. After she finds him, she no longer has reason to suppress her sadness and so can safely permit it to come forth.

In this everyday episode, the mother's sadness was not deeply repressed. However, a person may bring forth deeply repressed sadness once she unconsciously becomes assured that she may safely experience it. For example, a patient in analysis who felt rejected as a child tested the analyst in the fourth year of treatment by threatening to terminate. She carried on this test for months. Despite all the patient's objections, the analyst urged her to continue. The patient finally became convinced that the analyst was not simply being dutiful. She began to believe that he really wanted to keep seeing her. She then agreed grudgingly to continue. A few days later she burst into tears and brought forth a very painful memory of maternal rejection and neglect. The rejection had been so severe that the patient had concluded that her mother wanted her to die. The analyst, by urging her to continue, had provided the "encouraging atmosphere" that Bernfeld wrote about. He helped the patient to feel safe. She unconsciously decided that she could bring forth the sad epi-

sode of maternal rejection, which she had not thought about for many years.

A patient's permitting herself during treatment to weep over past disappointments is often an indication that she has begun to feel safer with the analyst.

Examples of Patients Confessing Secrets after Being Helped To Feel Safe

My examples, like Bernfeld's, will be brief and schematic. They are intended as illustrations of my approach, not as evidence for it. For evidence I rely on formal research, which will be presented later. Bernfeld did not assume, nor do I, that every time the patient is helped to feel a little safer, he or she will confess a major secret. However, when the patient does confess such a secret, it is because the therapist (or some significant event in the patient's everyday life) has helped him or her to feel safer.

In some cases the patient will feel safe enough to make a major confession only after the therapist has made a certain helpful intervention numerous times; in other instances, only after the therapist has passed a powerful test. In the case presented above, the therapist did both of these things. He repeatedly urged through interventions that emphasized the patient's fear of rejection that she should continue in treatment. For example, he told her that she was considering terminating in order to reject the therapist before he rejected her. He also told her that she had inferred from her parents' rejecting her that she did not deserve to receive much help. In several instances, after the therapist made an interpretation of this kind, the patient became a little more relaxed, a little more insightful. However, she did not make a major confession until the therapist passed a powerful test by urging her to continue in the face of her strongly stated intention to stop in a few days. It was after this that the patient showed relief, agreed to continue treatment, and produced a painful memory of her childhood.

A similar example occurred in the analysis of a patient who had felt unprotected in childhood and who had inferred that he did not deserve protection. He tested the analyst by frequently reporting having unsafe sex, seriously risking the possibility of getting AIDS. On numerous occasions the therapist interpreted the patient's self-destructiveness. Then, after one occasion when the therapist was particularly forceful, the patient confessed that his parents had repeatedly failed to protect him from being bullied by older children in the neighborhood and from sexual abuse. The therapist's protecting him gave him a sense of security and also the feeling that he deserved to be protected. This made it safe for him to remember his parents' failure to protect him.

Another example concerned a patient who could not decide whether to marry his girlfriend. The patient had described her as appropriate, attractive, and fond of him. However, he complained that he was not intensely excited by her. A crisis developed when the girlfriend, tired of the patient's indecision, insisted that he decide whether or not to marry her by a certain date. In his interpretations the analyst had indicated subtly that he thought the patient should marry the girlfriend. After discussing the case with a colleague, the analyst told the patient that the decision was entirely his (the patient's), adding that he would simply try to help the patient to figure out what he genuinely wanted to do. The patient reacted by weeping and remembering more about his father's making him comply with his unreasonable, severe stepmother. A short time later he decided to leave the girlfriend.

Still another example concerns a patient who, when feeling depressed, had occasionally urged the analyst to talk to her on the telephone. The analyst did not consider this necessary and consistently refused. Then, on one occasion, reacting to a change in the patient's tone (she seemed less strident and more genuine in her request), the analyst agreed to talk to her. The next session the patient brought forth a new memory: when she was eight, shortly after her mother had died, she lay in bed,

trying to wish her mother back and feeling helpless that she could not. The analyst's responding when she called had made it safe for her to bring forth the painful memory of her mother's not coming back.

My final example concerns a patient who entered analysis unconsciously afraid that she would submit to the analyst and then believe false interpretations or follow bad advice. She attempted to overcome this danger by persistently disagreeing with the analyst, and the analyst helped her by interpreting her fear that she would have to comply with him. After one such interpretation, the patient brought forth a secret sexual fantasy of being spanked by the analyst. She could acknowledge a sexual fantasy of submission to him when she had reassured herself that in reality she would not feel compelled to submit.

Research on the Effects of the Analyst's Interventions

We have used formal research methods to study patients' reactions to interventions that we assumed would clear away the obstacles to their bringing forth new material, that is, to their confessing. According to our approach (Weiss, et al., 1986; Weiss, 1990, 1993a, 1993b), the major obstacles stem from unconscious beliefs (termed by us "pathogenic") which warn patients that if they experience certain mental contents or seek certain goals, they will put themselves in danger. They repress such mental contents and goals in obedience to these beliefs. They bring forth the repressed material and move toward the inhibited goals when they are helped by the analyst's interventions to realize that their pathogenic beliefs are false and the dangers (including painful feelings of shame and guilt, and the expectation of severe punishment) they fear are not real.

Caston (1986) studied the question suggested by Bernfeld: Does the patient become more insightful after being offered interventions, including interpretations calculated to remove

the obstacles to gaining insight? Caston used transcripts of the analysis of Mrs. C, whose treatment had been transcribed for research purposes. This material enabled Caston to determine with considerable precision: (1) the level of insight in the segment of the patient's speech immediately before an intervention; (2) the value of the intervention for clearing away the obstacles to the patient's bringing forth repressed material; and (3) the level of insight in the patient's speech segment immediately after the intervention.

Caston was able to detect shifts in insight that the clinician would not be likely to notice. He found that Bernfeld's assumption held up. The patient reacted to an intervention that our judges assumed would help her to feel safer by immediately becoming bolder and more insightful.

Using an ingenious method reported elsewhere, Caston (1986, pp. 241-255) demonstrated from a study of the first ten sessions of Mrs. C's analysis that independent judges could agree on a formulation of her personality and problems. This formulation included statements about her goals, her pathogenic beliefs, the insights she would be likely to produce as she succeeded in changing these beliefs, and the tests she would be likely to put to the analyst in her efforts to change them.

Here is an abridged version of the formulations about Mrs. C similar to the one given to the judges:

> Mrs. C is a social worker who was twenty-seven years old when she came into analysis. She came primarily for sexual problems: she was unable to have orgasms during intercourse. She had an obsessive-compulsive character disorder. Mrs. C was burdened by an omnipotent sense of responsibility for her parents and siblings. She believed that if she were strong and independent with her family or with others, or if she were demanding of them, she would hurt them. She was afraid that she could push others around. She unconsciously wanted to acquire a capacity to be flexibly strong and oppositional. Mrs. C should benefit from interventions that would reassure her

that she could safely be independent with the analyst and with others, or that she could safely be critical of them, disagree with them, or withhold from them.

Caston now used this formulation to have independent judges rate each of the analyst's interventions during the first hundred sessions of Mrs. C's analysis according to whether and to what extent Mrs. C could use it to clear away the obstacles to confessing. Caston found that our judges' ratings of interventions were in considerable agreement—that is, they were reliable.

Caston's next step was to have a new set of judges use two scales to assess the speech segments just before the analyst's interventions and those just after them. One scale was to measure Mrs. C's insightfulness in these segments. This scale took account of the extent of Mrs. C's insights, the significance of the themes which she was insightful about, and the degree to which the insights implied integration. The other scale, the boldness scale, measured the degree to which Mrs. C confronted significant personal issues. The judges given the speech segments were not told where they occurred in the analysis or whether they came before or after the analyst's interventions. Caston found that the judges' ratings were reliable for both the boldness scale and the insightfulness scale. He also found that ratings for boldness correlated very highly (.9) with ratings for insightfulness, even though both scales were applied by different sets of judges.

Caston was now in a position to determine how Mrs. C reacted when offered an intervention that we judged would help her to feel safer. He correlated the degree to which Mrs. C's insightfulness and boldness shifted from just before to just after the analyst's interventions with the degree to which the interventions were rated as likely to help her to feel safer. He found that she reacted to good interventions by becoming bolder and more insightful and that this finding was statistically significant.

Caston also tested a hypothesis not taken up by Bernfeld, namely, that Mrs. C would react to poor interventions by becoming less insightful and less bold. This hypothesis was not upheld. Apparently, Mrs. C was helped by good interventions but not set back by bad ones.

Research on the Patient's Testing of the Analyst

In our research on the patient's testing of the analyst we studied one particular kind of test in which Mrs. C made an explicit or implicit demand on the analyst (Silberschatz, Sampson, and Weiss, 1986). As stated earlier, she was reluctant to be oppositional to her parents or others or to make demands on them. She feared she would hurt them or force them to yield to her. In the analysis, too, she was reluctant to be oppositional or demanding.

Silberschatz reasoned that Mrs. C would attempt to overcome her fear of making demands by testing the analyst. She would be demanding, and she would experience the analyst as passing her tests if he did not seem hurt or angered by her demands and if, while remaining calm, he did not yield to them. To test this hypothesis, Silberschatz took the following steps:

1. He had judges isolate from the first hundred sessions of the transcripts of Mrs. C's analysis all the speech segments in which she made significant demands on the analyst. These were demands in which, according to Silberschatz's hypothesis, Mrs. C was testing the analyst.

2. He had another set of judges determine whether and to what extent the analyst passed these tests by remaining calm and unyielding to Mrs. C's demands. These judges were given the speech segments in which Mrs. C made the demands and the analyst's responses to them but not the speech segments following the analyst's reactions.

3. He had several other sets of judges assess the patient's speech in segments just before the analyst's responses to the test and just after the responses. These segments were assessed by a variety of measures, each of which was scored by a different

group of judges. Segments were given to the judges in random order, without context; nor were the judges told whether a speech segment occurred before or after the analyst's response.

One scale used to assess Mrs. C's speech segments, namely, the experiencing scale, measures the degree to which the patient experiences what she is saying. A high experiencing rating indicates nondefensiveness, and it is strongly correlated with insightfulness (Fretter, et al., 1989). Another scale, the boldness scale, developed by Caston, was shown by him to be highly correlated with insightfulness.

4. Silberschatz correlated the degree to which the analyst passed the patient's tests with the shift in the patient's affects and behavior as determined by the various scales. He found a significant positive correlation between the analyst's passing the patient's tests and the patient's shifts in her levels of experiencing, boldness, and relaxation, and a significant negative correlation with the patient's shifts in her levels of fear and anxiety.

Silberschatz's findings support the hypothesis that, by her demands, Mrs. C was testing the analyst, rather than seeking gratification from him. Had she been seeking gratification, she would have become more anxious and less relaxed when the analyst frustrated her demands, rather than less anxious and more relaxed, as Silberschatz found. Silberschatz's findings also indirectly support the assumption that after a passed test the patient may become more insightful. Mrs. C's levels of experiencing and boldness both increased significantly after a passed test, and both are highly correlated with insightfulness.

Caston's and Silberschatz's pioneering research studies have been replicated and enlarged upon in numerous subsequent studies. These studies support the hypothesis that patients bring forth previously warded-off contents when they are helped by the analyst or therapist to decide that they can safely do so (Broitman, 1985; Bush and Gassner, 1986; Curtis and Silberschatz, 1986; Fretter, 1984; Fretter, et al., 1989; Kelly, 1989; Linsner, 1987; Silberschatz and Curtis, 1986, 1993; Silberschatz, Fretter, and Curtis, 1986; Weiss, 1993a, 1993b).

The Independence of the Analyst's Interpretations from the Content of the Secret

In his article, Bernfeld (1941) made the point that the analyst's diagnosis of the obstacles to the patient's confessing may be independent of the content that the patient eventually confesses. "[T]he exact content of the secret had been neither known nor guessed. As usually happens, it came as news to the analyst. . . . These communications are the facts to be observed, and the analyst gets them without illegitimately 'influencing them' " (p. 346). Here Bernfeld attempted to refute the persistent criticism of psychoanalysis that the analyst suggests the contents that the patient ultimately confesses.

In our research we have found support for Bernfeld's position. It is supported by the study carried out by Gassner, et al. (1982, 1986), in which they demonstrated that, in the case of Mrs. C's analysis, a number of previously repressed mental contents came forth without their ever having been interpreted or suggested by the analyst. Gassner and co-workers (1986) also demonstrated in the five-minute segments in which Mrs. C brought forth the previously repressed contents that Mrs. C was less anxious and that she experienced what she was saying more fully than in random segments. These findings were statistically significant and support the hypothesis that Mrs. C brought forth the previously repressed contents after she had been helped to feel safe by the analyst's matter-of-fact resistance interpretations and by his passing her tests by not yielding to her demands.

Another study supporting Bernfeld's position was carried out by Shilkret, Isaacs, Drucker, and Curtis (1986). They tested the hypothesis that as a consequence of working in analysis to master her problems, Mrs. C would become progressively more conscious of her sense of guilt, her omnipotent belief in her responsibility for others, and her exaggerated fear of hurting them. The investigators assumed that Mrs. C might accomplish this in the absence of interpretations. They found that she behaved in accordance with their hypothesis. "Mrs. C made progress to-

ward each new level of insight into her irrational fears of responsibility and guilt in advance of the analyst making an intervention at that level. It should be emphasized that the analyst rarely commented on the domain under consideration" (p. 214).

After completion of this study, the investigators discussed the analysis of Mrs. C with the treating analyst. They found that he had not included any reference to guilt or irrational sense of responsibility in his case formulation and that he had scarcely any interest in this area.

The Development of Insight

Bernfeld's view, as well as our research supporting it, throws light on the question: May insight occur as a consequence of a corrective experience which helps the patient to feel safe? This view, which was first stated forcefully by Alexander and French (1946), has been elaborated subsequently by other authors, including Kris (1956a, 1956b), Rapaport (1951, 1958), Sandler and Joffe (1969), and Rangell (1968). In my observation, insight may follow a corrective experience even in the absence of interpretation. However, the analyst's interpretations may play an important part in the patient's acquisition of insight, both by making the patient feel safe and by helping the patient to put into words self-understandings that previously were unconscious.

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COUNTERTRANSFERENCE AS INSTRUMENT AND OBSTACLE: A COMPREHENSIVE AND DESCRIPTIVE FRAMEWORK

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A comprehensive and descriptive approach to countertransference phenomena is proposed. Three types of mental activity are distinguished: the objective-rational *attitude is an adaptive, relatively nondefensive mode of observation; the* reactive *mental state corresponds to the classical notion of unconscious countertransference as an obstacle and a defense; by contrast the* reflective *attitudes involve preconscious and conscious psychical activity. Reflective activity involves four phases: (1) during emergence, an inner reaction appears; (2) immersion, through a regressive exploration, leads to introjective identification; (3) integrative elaboration involves a shift in cathexis, more distance, and an organization of the regressed contents, while (4) an interpretation is forming in mind. Three case examples from the literature serve to illustrate.*

INTRODUCTION

Countertransference has generated such an impressive number of observations, descriptions, and interpretations that Bofill and Folch-Mateu (1963, p. 35) remarked that "countertransference could encompass the whole of psychoanalysis" (our translation). A profusion of often incompatible viewpoints has given rise to numerous controversies about the definition and the uses of countertransference. In this paper, we wish to demonstrate the clinical relevance of an integrative conceptual model of coun-