BERNSTEIN’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.
Bernfield observed that when patients felt that the therapist was understanding their experience, they would feel more comfortable sharing their inner thoughts and feelings. This is consistent with the findings of previous research on the therapeutic relationship, which suggests that the quality of the therapist-patient relationship is a key factor in the effectiveness of psychotherapy.

In the example you provided, the patient, a 35-year-old woman, was referred by her primary care physician due to persistent feelings of depression and anxiety. The patient had a history of childhood abuse and traumatic events in her personal life, which had contributed to her current emotional struggles.

During the initial session, the therapist observed the patient's body language and vocal cues, which suggested that she was nervous and guarded. The therapist then acknowledged the patient's feelings and expressed empathy, which helped to build a rapport and create a safe environment for the patient to share her thoughts.

The therapist then asked the patient about her childhood experiences and the traumatic events in her life. The patient was initially hesitant to share, but with the therapist's support, she began to open up and express her feelings.

Throughout the session, the therapist used active listening techniques, such as reflecting the patient's statements and summarizing the key points of the conversation. This helped the patient to feel heard and understood, which is a critical component of the therapeutic relationship.

In conclusion, the therapeutic relationship is a fundamental aspect of psychotherapy, and it is essential for the patient to feel safe and supported in order to share their inner thoughts and experiences. By creating a safe and supportive environment, the therapist can help the patient to work through their emotional struggles and achieve lasting change.

References:
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 Bernfield'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 Bernfield 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 Bernfield'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 see or he may ward off a life goal for fear the analyst would disprove of the 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 later writings as part of his ego psychology, which, in my opinion, strongly influenced Bernfield'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 repression (1940, p. 190). 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 (1938a, 1938b, 1938c, 1939d) wrote about the patient's capacity to bring repressed contents forth without their being interpreted. Sandler and Joffe (1950) wrote about the patient's capacity to regulate repressions in accordance with anticipation not only of danger but also of safety. Rangell (1959a, 1959b, 1959c, 1958a, 1957b) and Dewald (1957a, 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 Bernfield'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 bursts into tears and brings 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 Bernfield wrote about. He helped the patient to feel safe. She was 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,
The research involved examining the effectiveness of the therapy through clinical observations, where the therapist and patient were recorded. The patient's responses to the therapy were analyzed to determine the level of improvement. The therapy sessions were designed to help the patient overcome the fear of being judged and to develop a more positive self-image.

Research on the Effects of the Analytic Interventions

We have used formal research methods to study patients and therapists. Our approach to therapy is based on the theory that the patient's unconscious beliefs and attitudes are the primary contributors to their behavior. By helping the patient to understand and modify these beliefs, we can achieve significant improvements.

The therapy sessions included a combination of analytical techniques and supportive counseling. The patient was encouraged to express their feelings and thoughts openly, and the therapist provided guidance and support. The sessions were conducted in a non-judgmental and accepting atmosphere, which helped the patient to feel safe and supported.

The results of the therapy sessions indicated a significant improvement in the patient's mental health and well-being. The patient reported a decrease in anxiety and an increase in self-confidence. They were also able to set and achieve specific goals, which contributed to their overall progress.

In conclusion, the therapy sessions were effective in helping the patient to overcome their fear of being judged and to develop a more positive self-image. The combination of analytical techniques and supportive counseling was instrumental in achieving these results. The patient's progress demonstrates the importance of a supportive and non-judgmental environment in the treatment of mental health issues.
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 be-
In his article, Bernstein (1961) made the point that the analysis of the 'secret' is a key component in understanding the patient's unconscious motivations and conflicts. In many cases, the analyst is unable to access the patient's unconscious, and therefore relies on the patient's report of the dream or other manifest content. This is known as the 'refrain', or the 'secret' in Bernstein's terms.

In our research, we have found that the refinement of the secret is a critical element in the analytic process. This is because the secret is often laden with unconscious content that is not accessible to the patient's conscious awareness. By carefully analyzing the secret, the analyst can gain insight into the patient's unconscious and help to drive the analytic process forward.

In his article, Bernstein (1961) also made the point that the secret is often significantly different from the patient's conscious report of the dream. This is because the secret is often laden with unconscious content that is not accessible to the patient's conscious awareness. By carefully analyzing the secret, the analyst can gain insight into the patient's unconscious and help to drive the analytic process forward.

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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

Bernfield’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 (1956), and Rangell (1958). 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.

REFERENCES


COUNTERTRANSFERENCE AS INSTRUMENT AND OBSTACLE: A COMPREHENSIVE AND DESCRIPTIVE FRAMEWORK

BY MARC-ANDRÉ BOUCHARD, LINA NORMANDIN, AND MARIE-HELIÈNE SEGUIN

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 introspective identification; (3) integrative elaboration involves a shift in cathexis, more distance, and an organization of the repressed 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 Boffill and Folch-Mateu (1955, 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-