How to “Enter” a Psychoanalytic Process Conducted by Another Analyst: A Self Psychology View

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The evolution of a psychoanalytic process is codetermined by what each participant brings to it. Hence, the analyst is ever mindful of letting the patient’s contribution emerge as spontaneously as possible. Looking at this process rather grossly, we may perhaps still agree with Freud that, just as in a chess game, only the opening and closing moves are well defined; while those in between are of an endless, unpredictable variety. Still, we often speak of a “standard procedure”—which exists only if we look at the psychoanalytic process in a very distant and highly abstract way. When we examine any sample of this process under the microscope, however, neither the chess-game analogy (except for the in between phase with its endless variety), nor the idea of a “standard procedure” holds true. Any entry into a psychoanalysis—as well as the full journey through it—is always highly idiosyncratic for both participants, no matter how we may generalize about these entries. On this microscopic level there is nothing “standard” or “well defined” about the precise conduct of an analysis, because no two analyses are ever alike, even if they are not haphazard and have their definite, well-articulated general “rules.” To put it more explicitly, when patient and analyst embark on their joint venture, the most highly personal and deepest layers of the patient’s inner life will progressively emerge, depending very much on how felicitously these will be met by the responses of the analyst. “Felicitous” here means how well the analyst will be able to understand the patient’s communications, how well he/she will be able to get this understanding across (verbally and nonverbally), and finally how well this will enhance the patient’s deepening self-explorations by making him/her feel understood. The felicitousness of the analyst’s responsiveness, then, is gauged by the immediate and long-range success in achieving this goal. The criteria for this success are available only within each analytic process—we can only judge what is optimal by how the patient responds to it. Therefore, only the criteria intrinsic to the process remain valid, even if we legitimately try to arrive at useful generalizations regarding the nature of desirable interventions and outcome. Such generalizations serve as guideposts of limited usefulness in any specific analysis.

The focus of analysis is the patient’s subjective inner world, and the method of its exploration is the patient’s introspection (expressed in the form of free associations) and the analyst’s vicarious introspection (empathy), aided or hampered by his/her theories. The actual analytic work is a monumental task, which no analyst has yet described to every other analyst’s complete satisfaction. Broad descriptions of how an analysis is to be conducted are more or less easily agreed upon by like-minded analysts, but their scrutiny of a specific analytic process will nevertheless lead to as many views as the number of those who participate in such a study.

How much more delicate and difficult, then, is the task of entering into an analysis conducted by another analyst—one that we can only experience vicariously! Here we have to be able to enter not only the patient’s inner world, but that of the analyst as well. This oscillating vicarious introspection is well known to us from supervisory experiences. In this exercise the “text” is all we have, and we have to alternate between feeling and thinking our way into the patient’s experiences at one moment, and into the analyst’s experiences at another. We cannot grasp how patient and

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analyst experience each other if we remain extrospective observers and use as the criteria of our assessment how we would have understood the patient and what our interpretive responses would have been. When we propose our own supposedly more accurate or more suitable responses with hindsight—as we so frequently do in clinical conferences and in formal discussions of analyses done by other analysts—we are already dealing with another analysis, the one we just conjured up, and not with the one under consideration.

I shall therefore try to enter the analytic process described by Fosshage and to stay with and understand what he and his patient experienced, entirely from within their own perspectives. I shall discuss the clinical data from within those perspectives, without trying to conjure up a process that might have developed between P and myself, had I been her analyst and had I heard a different meaning in her communication of her subjective experiences.¹ And then—and only then—shall I survey this analysis and raise questions from within my own clinical and theoretical perspective.

I turn to the Wednesday session first, skipping the introductory material for the time being, in order to find the “live” examples of the patient expressing something to the analyst that required a

¹There is no question that I—as well as every other analyst—would have inevitably heard Fosshage’s patient differently, since each of us would have responded differently to the way the patient presented herself for analysis and because each of us would have evoked a somewhat different set of subjective experiences in the patient. It is the manner in which each analyst responds to what he/she evokes and then hears that makes for a successful or unsuccessful collaboration between patient and analyst. In this sense there is certainly no “standard procedure.” (Adhering to the external trappings of an analytic setting and even to a few of its basic rules does not make the procedure “standard.”) The analytic task is in the processing of the emerging communication which is unique for each patient analyst pair. The rules refer to the nature of this processing and not (more narrowly) to what is being processed—although the various psychoanalytic theories do circumscribe the content areas from their varying vantage points. What is supposed to unite all analyses in spite of their idiosyncratic differences, is the focus on the emerging transference, which is the amalgamation of what the patient brings to the analytic setting as well as what the analyst brings to it. But even our view of the transference, and how we work with it, is now so varied that this no longer satisfactorily safeguards the erstwhile “unity” of analytic work. I am mentioning this here only to underscore the difficulties encountered in discussions such as the present one.

response, some form of an immediate intervention. In other words, I shall search for what I call “encounters” between analyst and patient, to discern what goes on “inside” each of them. An encounter may encompass several exchanges on the same topic, such as P’s initial presentation of her reluctance to come to the additional session and the subsequent effort at understanding her motives for it; or it may be very brief, such as the exchange about whose Cadillac was in the analyst’s driveway. Looking carefully at several such encounters helps to get acquainted with the patient’s as well as the analyst’s style of relating—especially the affective tone in which they communicate with each other. Specifically, I want to know whether they are on the same wave-length; whether they meet each other on the same track or, talk past each other. Such an endeavor is usually more fruitful when the analyst is immersed in the patient’s experiences for some period and does not frequently interrupt the flow of the analytic conversation; when he lets the patient elaborate and does not direct her attention toward finding “reasons” or “explanations” or “logical coherence” in her communications; or when the patient is permitted to sidestep questions she experiences as obstacles to her own affect-laden explorations. In other words, when the analyst can live for periods of time with intense affects and unsettling ambiguity—preconditions for mobilizing archaic layers of the transference, which then require understanding and explanation. Another important element here, both in the conduct as well as in the discussion of an analysis, is the oscillation between a microscopic focus on the immediate experience and on what had gone on in the analysis before (during the last session, the last months, or even longer) and a macroscopic focus on how all of this is reflected from the broader genetic/dynamic background, in which each encounter is embedded. Of course, the microscopic detail cannot be fully understood without its immediate as well as its wider analytic and broader genetic/dynamic context. My initial approach in entering this analysis in the next section will therefore inevitably suffer from the lack of this wider context.
Encounter #1

P. opened her (newly added) Wednesday session dejectedly, stating that she came reluctantly; she did not like the additional session. Her feelings about this appeared vague and not yet well formed at first. The analyst immediately began to probe for specific reasons for her feeling the way she did. After dismissing a few possible explanations (one he suggested as well as her own), the analyst landed on the idea that it would be too hard to generate enough material, which was making her feel annoyed and resentful.

Comment

Let us look at the initial interchange from each participant's perspective. While both participants were in a dejected mood, the analyst expressed her immediate concern about her reluctance to come to this new session concluding with the fear that she would have trouble generating enough material. The analyst was quite taken by this explanation. This is evident from the fact that he reflected it back to the patient, adding to it what he felt had just become clarified: "So that is what interferes with your freedom just to be here."
emerged just now. P responded: “Yeah, I think these things about you that are . . . (hesitatingly) . . .” The analyst interrupted, as if to help the patient overcome her hesitancy (rather than live with it for a while) and quickly said: “I understand you don’t want to hurt me, but we’ll have to take that risk.”

Comments

P could recognize that coming to analysis more frequently threatened her efforts to keep her critical feelings toward and dislike of her analyst under raps and to retain her idealized image of him. Now that she felt more certain (as a result of analytic work thus far) that he liked her, and that she did feel likable, she was afraid that she would turn on him, just as she turned on her husband soon after they got married. P was confused about how her analyst’s caring about her related to her concern that she might now become severely critical of him and thereby hurtful to him. The analyst did not understand this connection clearly enough either, but he communicated to her what he had observed: the sequence of her “being cared for, diminishing idealization, and emergent criticism”—without exploring the connection further at that moment, or letting P struggle with that issue in a state of confusion for a while. Nevertheless, the mere reflection of the sequence seems to have triggered an effort on P’s part to explore it further—albeit “hesitatingly.” Here the analyst rushed in, ostensibly to help her overcome her hesitation and encourage her to face what she feared. He addressed directly (rather than interpretively) what he considered to be the reason for the patient’s momentary hesitation. We should look in the next encounter for the impact of this intervention.

Encounter #3

P’s response is immediate. She blurts out a disapproving remark (an apparent nonsequitur) which turns out to lead analyst and patient to the core issues: “I didn’t like the car in your driveway.” After several interchanges about the car, its possible meaning in terms of what it might have revealed to her about her analyst, P directly asks if it is his. The analyst simply replies: “It wasn’t my car.” The patient was pleased at both the response and that the analyst answered her question directly. There was apparent relief on both sides. The analyst felt that an “unnecessary impasse” had thereby been averted, and—that what is most significant—was immediately able to bring back into analytic focus the issue of P’s disappointment in him. P searched for answers and thought that as the analyst became less idealized in her eyes, he became more accessible to her observations or she was more willing to see certain things about him, “including some things I can’t stand.” This aversion led to comments about his sweaters that make the analyst look old (as does the Cadillac) disturb her fantasies of seeing him as young and available. P is here very clear about what it all means, and she says: “I think I have been able to get a lot of energy from liking you and from thinking about you and having fantasies about marrying you.” The Cadillac and the vesttype sweater disturb these fantasies “and if it suddenly turns out that [you are] an old man who drives a Cadillac, that energy is gone.” P then adds something that clarifies her earlier somewhat obscure statements about the relation between the analyst’s caring about her and her criticisms of him: “Now, I know we’ll be friends and that you will care about me and all of that; but I’m losing something”—she is apparently referring to her idealization of him that provided her with additional energy. The analyst responded with a more comprehensive understanding, and there was at the end of this session a remarkable meeting of minds.

Comments

It would be easy for the external observer to take the analyst’s direct and explicit counsel: “we’ll have to take that risk” as by-passing or overriding P’s hesitancy, rather than letting her experience it for a while and then analyzing it. It is noteworthy, however, that—looking at it from within the ongoing process—P immediately responded by expressing her hitherto withheld criticism of the analyst—albeit indirectly at first, making the Cadillac
Aspects of the patient's transference longings (which thereby become available for working through) then this first recorded session appears to have an unqualified success. However, since the issue of one isolated session only, it is now appropriate to examine the analyst's introductory statements and thereby amplify Foschino's succinct and evocatively introductory richly illuminating the context in which the first session took place. A significant, the previous analysis enabled P to curtail his "use of drugs, alcohol, and promiscuity." She ended up chronically and apparently frequently requested, 'if not demanded, to know that her analyst "cared" about her. The analyst was apparently stung by her "reactions," as he felt "angry" which made him "care." He was evidently, which made him feel had he been "walking" the case and terminated that analysis.

P came to Dr. Foschino with her "depression, hopelessness, and despair," but still "emotionally available" [for further analysis] and desperately searching for help. P's family background, her significant childhood trauma, and her transference manifestations interwoven in Foschino's presentation with what began to emerge in their analytic encounter.

Mrs. P's intense mirroring and archaic idealizing needs and their often preemptive quality were well illustrated through the rapidly evolving relationship. The roots of her intense need to know that she is "cared about" [along with her needs for recognition and affirmation] as well as the roots of her "romantic and sexual" feelings toward her analyst are amply documented in Foschino's reconstruction. They illustrate the many painful transference disruptions referred to during the first year of this second analysis—leading the diagnosis of a self-disorder and the formulation of the first two-and-a-half years of analysis up to the project also includes those manifestations of the transference which highlight...
A "Biopsy" From the Evolving Process: The Consistency With Which Two Minds Meet

Session Two

P starts her Friday session with a complex but transparent transfer, in which she has to respond to extreme pain and suffering in others. She is not able to express herself in her dream from the previous session highlighting further her need for action. Her association to the analyst's neediness in relation to the project and more immediately to her need for a "keep him idealized". She would often have to experience him as weak, needy, or in pain. She last rode in a Cadillac at her husband's funeral—dying or dead man on the dream—reminding her of someone who reminded her of the analyst. She sees in the analyst the impact on her own problem. It is often helpful to experience her as "suffering and frightened". The analyst continues to share his expanded understanding with his patient. "And if you are critical of me, you are suffering and frightened." He is determined not to avoid the impact of the first interventions. He will try to minimize the therapist's previous experience and not repeat the same.
afraid that I will not be able to withstand it, that I will fall apart or throw a tantrum and that you will lose me in this suffering dead space.” After the patient’s confirmatory response the analyst goes further with his references to the dream and aptly enlarges on the issues of the previous session, thereby reconstructing the process of the previous as well as the present session.

Comments

P begins with a dream that deals profoundly with the themes of the previous sessions and brings forth the complexities of her current transference longings as well as her defenses against retraumatization. Suffice it to say that the analysis of the dream leads here to an impressive meeting of minds. Analyst and patient spoke meaningfully to each other—they met on the same track and their analytic dialogue palpably deepened. They now understand more clearly how the analyst’s perceived vulnerability brought forth important transference feelings, whose genetic origins could also be reconstructed. The analyst was comprehensively interpretive throughout. The continuity of the main theme and its further elaboration is impressive. Our initial impressions are further consolidated.

Session Three

P began her Monday session with a report of a painful exchange with her mother during the weekend that continued the theme and horror of the crypt dream. Recalling this exchange and the rage she felt toward her mother brought back a poignant memory (of age eight or nine) when mother’s neediness was at its extreme during her severe depression and evoked the same horror P felt in the crypt dream. The patient herself noted that her dream and the recall of this experience with her mother ushered in a shift of focus in the analysis away from father to mother—which the patient called “the area of the deeper connection.” Analyst and patient could now see and discuss that P’s diminishing idealization brought forth the fear that the analyst would be “the suffering, deathlike and needy person who is both draining as well as unavailable for her”—in a sense warning herself not to become more deeply involved with him.

Comments

P’s analysis of the experience with her mother, as well as further thoughts about the dream led both patient and analyst to a better appreciation of the “walking corpse” image, hence the nature of the traumatic early mother-daughter relationship. This illuminated the reasons for P’s search for the “intensity” in being mirrored; and her turning to a “romantic and sexualized” relation with the analyst when such mirroring failed to be forthcoming in the transference. P herself recognized that the dream as well as what she had begun to focus on in her analysis signaled a shift from being preoccupied with her relation to her father to her relation with her mother; a more dangerous and frightening territory—as the dream poignantly portrayed. P’s perception of the analyst as weak, “the suffering, deathlike, and needy person who is both draining as well as unavailable for her” ushered in the mother transference and made it palpably immediate and concrete. The impact of the project (which revealed the analyst’s neediness), his growing old and becoming unavailable to her (driving a Cadillac and wearing vestlike sweaters), ushered in her entering the (more horror-filled) world of her mother, which made the analyst appear to her as a “terrifying image” in the shifting transference. This shift definitely heralded a deepening of the transference, hence unambiguously reflecting significant progress. Again the analyst remained consistently interpretive and kept the central focus on the transference.

Session Four

P continued the central theme as she began her Tuesday session “feeling hopeless.” The threat of the neediness of others she was in
close relationship with, she realized over the weekend, made all close relationships impossible for her. The analyst, in tune with Mrs. P's affect, reminded her of the origin of her vulnerability. She claimed to know this, but asked directly, nevertheless: "how am I going to change that?" The analyst described (within the patient's idiom) his view of the working through process; how P will be able to manage her pain, and offered a reassuring direct response to her genuine reflective question, holding out some hope for change. She was apparently reassured some, but asked: "You really think so?" And the analyst unhesitatingly and quite naturally responded: "Yes. I really do." The analyst experienced this as "a poignant moment in which P shaken by the events of the past week was searching for and... began to experience renewed hope that these profoundly disturbing repetitious reactions to neediness should not go on forever."

Note that P, in return, was able to reflect on what she found most helpful in these last few sessions. In her mind the most important benefit came from the fact that she was able to criticize her analyst with impunity. She reminded herself and her analyst that as a result they were now getting into "the deeper connection," which she both wished and dreaded.

She then elaborated on her recent exchange with her mother as well as on her early memory of her mother's depression. The session ended with a significant resolution for the moment: "I am feeling I don't know where things are going from here. I came in feeling that they were not going to go anywhere. Now, I'm just feeling that I don't know and that's sort of alright. I am calm about that..."

Comments

The work of the preceding sessions appears to have reawakened P's "feeling hopeless" about being able to sustain close relationships. The analyst was again direct and reassuring in response to the patient's genuinely reflective question and did not view it as a resistance: he held out some hope for change in his response.

Rather than creating thereby an attitude of "pushing things under the rug,"—as might be expected—communication opened up further. P was able to tell the analyst what she found most helpful in the last few sessions. She focused on the fact that she had been able to tell the analyst what she despised about him because she felt that he was strong enough to take it—which permitted her further progress. She was right. The telling itself indicates a reversal of a childhood solution to her predicament with her mother, to whom she could not tell; to whom she could not stand up until the end of her recent conversation. The same theme is present in the crypt dream, where she was finally able to extricate herself from an untenable situation by leaving the scene, which in her childhood she could not do. I take both of these reversals of old solutions as evidence of structural change in progress.

*Some Reflections From the Perspective of Self Psychology: What Sort of Focus and Responsiveness Does the Theory Prescribe?*

In my first cursory reading—as so often happens—I remained an external observer and found myself critical of each of Dr. Fosshage's early interventions. I did not even perceive clearly the progress that was made by the end of the first session. How could there have been substantive progress if the interventions were so "un-analytic," so "nonexploratory?" That is how some of them appeared to me when I looked only at their manifest form and content, without considering how the patient reacted to them and what might have motivated the analyst to respond in that fashion—that is, when I considered them outside of the ongoing analytic process. How could there have been progress if Fosshage intervened without giving the patient an opportunity to struggle with her feelings?—was my hasty and superficial conclusion. I glanced at the remainder of the sessions briefly, from the same perspective and in the same mood, and I put the manuscript aside, regretting that I had accepted the invitation to discuss it.
DISCUSSION—SELF PSYCHOLOGY VIEW

Paul H. Ornstein

Much later, recalling only my dissatisfaction but none of the actual content of the first session, I realized that I had violated my own rules never to stop at the external observer’s view in attempting to grasp what goes on in an analysis conducted by another analyst. It was after that reflection that I systematically approached the first session (divided into three encounters) and made the effort to enter the analytic process systematically, step by step, and examine it from within. The results were dramatically different.

Having thus studied the process from within, I shall now reflect on Dr. Foshage’s conduct of the analysis—a rather outside view. Although, on the contrary, the scrutiny I am about to apply is that of the external observer vis-à-vis the particular analysis. But even as that analysis had been conducted, I shall restrict myself to assessing only the content of our work. I shall refrain from concerning myself with anything I found the patient’s and Dr. Foshage’s understanding of why the analysis ended. I will not inquire into the implications of the patient’s symptoms, the way in which treatment was or was not related to the symptoms, to the patient’s illness, or to the patient’s illness.

I shall not inquire into the analysis of the interaction between the patient and the analyst, except as it affects the patient’s illness. I shall not inquire into the interaction of the analyst and the patient, except as it affects the patient’s illness. I shall not inquire into the interaction of the analyst and the patient, except as it affects the patient’s illness. I shall not inquire into the interaction of the analyst and the patient, except as it affects the patient’s illness. I shall not inquire into the interaction of the analyst and the patient, except as it affects the patient’s illness. I shall not inquire into the interaction of the analyst and the patient, except as it affects the patient’s illness.

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The evolution of P’s transference to the second analysis but in our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relationship, our relation
few and far between, they were clearly in the service of enhancing the analytic dialogue. They appear to have been prerequisites for the subsequent successful employment of interpretations. In other words, whatever the analyst ends up saying or doing has to be in the service of facilitating analytic understanding and explaining. Dr. Fosshage adhered to this principle with consistency.

How could we describe the clinical atmosphere in the sessions presented? And how could we characterize the nature of the analyst’s interventions from the perspective of self psychology?

The external observer might wonder about the extent and intensity of Dr. Fosshage’s empathic immersion in P’s transference experiences, especially during the first of the four sessions. The rapidity with which he intervened, the interruptions of some of the expressions of P’s affects and the explanations offered without a prior, clear-cut, and sustained phase of understanding them might give the impression of a more content-oriented, cognitive approach that did not focus adequately on the patient’s immediate subjective experiences. But—as demonstrated in the survey of the sessions—this view can be maintained only if we disregard the patient’s subsequent responses and the preceding two-and-one-half years of analytic work. My view from within the process led me to the conclusion that a “deep connection” was established between analyst and patient in this analysis and that the project did not substantially disrupt this connection on the part of P as much as it has (perhaps) initially done on the part of Dr. Fosshage, who thus opened himself courageously to the public scrutiny of his analytic approach by his colleagues.

Although the sample sessions do not contain clearly identifiable interventions we could characterize as “understanding”—the first step in the two-step approach to the interpretive process—they are interwoven with the analyst’s explanatory or reconstructive comments. Does this omission of understanding as a separate step interfere here—as it often does—with the mobilization of archaic layers of the transference? It clearly does not, probably because of the prior analytic work in which understanding alone must have played a leading role. The results of this prior work might also explain why we are not witnessing in these sessions examples of repeated, gross transference disruptions and their repair—the focus of much of the analytic work in a properly conducted analysis from a self psychological perspective.

Would this phase of the analytic process have been substantially different had the project not been undertaken and had this portion of the analysis been reported subsequently from the analyst’s detailed process notes—implying that the analyst’s specific anxiety about exposure would then not have arisen and his input would have been somewhat different? I doubt it. What did emerge convinced me that P’s core psychopathology had been mobilized in the transference and was the target of the working-through process, with beginning modifications of the patient’s habitual, defensive solutions—the hallmark of a well-running analysis. Remarkably, the project (and the analyst’s anxiety in connection with it) did not derail this analytic process. Rather, it served to mobilize important archaic layers of P’s psychopathology in the transference, which the analyst was able to work with interpretively.

But the above question is essentially an uninteresting one because it could only be answered speculatively, an approach which I have tried to avoid in this essay. A more interesting question is: What does the analyst think of all of the various interpretations of his work offered by the panel of discussants? From his response each of us will be able to learn more.

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