SOME REFLECTIONS ON
THE THERAPEUTIC USE OF THE SELF

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Until I was invited to prepare this paper, I had thought very little, if at all, about the general issue of the therapist's use of self or, more specifically, about how I might be using myself with my patients. I do think a great deal, however, about the countertransference experience that might arise in a particular therapeutic interaction. I routinely reflect both upon the emotional impact my patient is having on me and the possible impact his or her impact on me might be having on the patient.

With those patients who enter treatment having already achieved sufficient self-other differentiation to tolerate the fact of my otherness and separateness, I find that I am more or less free to be myself. Because such patients seem to thrive on the give-and-take of the therapeutic interaction, I find that at most times I am able to function in an object-related mode, contributing my thoughts and feelings as they occur to me with minimal consciousness of self.

With other patients I find myself functioning, more often than not, in what might be said to be a dual mode of self; that is, I am divided into an experiencing self and an observing self. These are patients who have been unable to achieve a high level of self-other differentiation. I find that my main task vis-à-vis such patients, both in the individual and in the group setting, is to discover, by trial and error, those uses of myself that prove to benefit them therapeutically and those that do not.

I am referring particularly to patients who can only feel comfortable and safe with me if I permit them to include me within the sphere of their omnipotence. Any expression of my separateness and otherness might prove to be experienced as threatening, even as potentially annihilating. This requires me to keep a low profile, which I might implement as the situation calls for it in some of the following ways.

I might spend many sessions, sometimes over a period of many months and sometimes extending into years, allowing myself to be distanced and neutralized, speaking only when the patient either directly or indirectly indicates he or she might need my participation, limiting my communications mainly to questions about whether or how I should be participating.

Sooner or later I am likely to experience myself as the object of the patient's anger, hate, and denigration. At such times my interventions are likely to be

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limited to comments and questions reflecting a more-or-less matter-of-fact acceptance of, and a curiosity about, my patient's view of my various faults and deficiencies. All the while that I might be engaged in such an inquiry, inwardly I am likely to be experiencing the patient's attributions as grossly distorted.

Should the patient escalate the denigration and attacks to the point that I find abusive, I might have to counterbalance his or her aggression with some of my own in order to signify my capability to survive his or her destructiveness and to awaken the patient from what might be a megalomaniacal ego state, thereby reestablishing the reality of a two-person situation.

During those times that I am allowing myself to be included within the sphere of the patient's narcissism and omnipotence, I find it sustaining to remind myself that I am serving the patient's therapeutic need to have me function as a maturational agent (Spotnitz, 1969) and that this requires me to contain and process the dysphoric experience that issues from the patient's need to use me as the target and depository of the unwanted and unbearable mental contents that he or she must urgently evacuate and project.

During such times it helps me to understand that the patient needs me to accept the feeling that I have little or nothing of value to offer and that the patient needs me to resolve the paradox of learning how to function competently while feeling incompetent.

While I might feel impotent, hopeless, or even despairing during this phase of the treatment, on a cognitive level I usually manage to sustain sufficient confidence in an eventual positive outcome to enable me to persist in the work.

As the therapeutic process carries forth processes of separation-individuation, I can expect the patient's omnipotent defenses to become eroded, and I can expect that he will gradually come to understand, as a simple matter of fact, both that his progress depends on my competence to do good-enough therapy and that my competence is not within his control. The patient will have given up the fantasy that he can wrest favors and caregiving from me by inducing feelings of badness and guilt.

As I emerge from the patient's sphere of omnipotent control I can expect to feel a diminution of my chronic bad or not-good-enough-therapist feelings and to feel myself more often to be a person rather than an object of the patient's malevolent transformations.

At this stage of the therapy, however, my increased freedom to be myself vis-à-vis such patients will lead me, at times, to behave in ways that fail to take account of their heightened sensitivity to slights and disappointments—especially in the group setting. The patient's increased capability for engaging in a normal object-related give-and-take may lead me to forget that he or she is, in fact, vulnerable, as never before, to my empathic failures. Winnicott (1958) has described the emotional position of a patient at this stage of the therapy as follows: "Eventually the false self hands over to the analyst. This is a time of great dependence and true risk."

Using a segment of a group session, I would like to illustrate the work that I typically have to do with my self-experience when confronted with such a patient's emotional upset following an empathic lapse on my part. I believe this interaction constitutes one in a series of ordinary therapeutic moments that carry forth such maturational processes as separation-individuation and the gradual growth of ego organization and strength.

I should say that my confidence in my conduct of the therapeutic interaction will be sustained only to the extent that I see evidence of therapeutic effect. For a given patient this might be one or more signs of increased ego-strength,