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Analytic Impasse and the Third: Clinical implications of intersubjectivity theory

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The author examines the notion of the third within contemporary intersubjectivity theory. He utilizes a variety of metaphors (the triangle, the seesaw, strange attractors, and the compass) in an effort to explain this often misunderstood concept in a clear and readily usable manner. An argument is made to the effect that intersubjectivity theory has direct implications for clinical practice, and that the notion of the third is particularly useful in understanding what happens in and in resolving clinical impasses and stalemates. Specifically, the author suggests that certain forms of self-disclosure are best understood as attempts to create a third point of reference, thus opening up psychic space for self-reflection and mentalization. He provides a clinical case as well as a number of brief vignettes to illustrate the theoretical concepts and to suggest specific modifications of the psychoanalyst's stance that give the patient greater access to the inner workings of the analyst's mind. This introduces a third that facilitates the gradual transformation from relations of complementarity to relations of mutuality.

A bright, talented, and experienced supervisee, whose office is in downtown Manhattan, presented a dilemma to me in consultation soon after 9/11. She was treating a man who, following the calamity, confided in her that he actually was not very upset about the event. As a matter of fact, he said, he found the whole thing exciting and energizing. During the morning of September 11th, he stood upon his Manhattan rooftop, like many New Yorkers, with binoculars and camera in hand, and in the aftermath of the attack he was glued to CNN enjoying the prospect of war. My supervisee told me that she was privately horrified by his callousness. She had long known of his narcissistic tendencies but was not sure how to approach this material. She, like so many of our colleagues in the psychoanalytic community, had been volunteering her time and was actively engaged in disaster-relief efforts. It disturbed my supervisee to think that such raw aggression and pitilessness could so dominate her patient's mind. She told me that in the midst of the session she became determined to make every effort to sustain 'an empathic stance.' She found this quite difficult and uncomfortable and doubted that she could maintain an empathic attitude in any way that felt genuine.

As a supervisor, I had the distinct advantage that I was not caught up in the immediacy of the transference-countertransference enactment. I was able to help my supervisee to see that there were many ways of understanding her patient's reactions on the basis of what we already knew about him. For one, her patient had a chaotic inner life, filled with images of violence, unconscious fantasies of bodily damage, and themes of sadomasochism. It seemed to me quite understandable that her patient felt relief in the midst of the city's catastrophe, simply because, at least momentarily, the violence and chaos, the destructiveness and the destruction, were externalized, concretely taking place, for once, not in his own mind but externally in the world of others.

I pointed out that, with the patient so directly barraging her with his aggression, it would be hard to know what it might mean to him if she responded with exaggerated or feigned empathy. Together we explored to what degree my supervisee had become fixed in her identification with the victims and the rescuers, thus locking her patient into his reciprocal identifications with the powerful and frightening terrorists. But, from the reverse perspective, how much was the patient's being locked into one set of identifications pushing the therapist into identifying with the complementary roles? As Davies has written,

Such cases of apparently inescapable therapeutic impasse always pose for me the dilemma that patient and analyst become prisoners of the coercive projective power of each other's vision; each becomes hopelessly defined by the other and incapable of escaping the force of the interactive pull to act in creative and fully agentic ways.

(2003, pp. 15-6)

As we will see shortly, what Davies here refers to as the coercive projective power of each other's vision, and of being defined by the position of the other, is closely related to what Benjamin has called 'complementarity' (1999, p. 203).
This initial supervisory discussion, though tentative and incomplete, allowed my supervisee to begin to genuinely empathize with her patient. The therapist had tried to sustain ‘an empathic stance’ as a technique because she could not at the moment come to any meaningful sympathetic understanding of her patient due to a temporary blockage in her free-floating responsiveness to experience shared identifications. She might have confronted his indifference and aggressiveness in an attempt to resist his assault and prevent his hijacking of the analysis. But, while an expression of her shock and disgust might have been spontaneous, it would not only have been unempathic, it also would have obscured a great deal of my supervisee’s authentic, although not immediately available, loving feelings for her patient.

As a supervisor, I often feel that my job is to give a nudge to the analyst’s relational compass, freeing the analyst to take up more varied identifications and relational positions, which in turn, since the analytic dyad is a complex system, may encourage the patient to assume new roles. As Davies and Frawley (1994) illustrate in their groundbreaking work with adult victims of childhood sexual abuse, it is essential that the analyst remain open to take up all of the patient’s multiple unconscious identifications: with victims and terrorists, rescuers and witnesses. My supervisee was caught between two perceptions, two contradictory organizations of her experience. She could be outraged at her patient’s indifference and heartlessness, but then she felt unempathic and unresponsive to his therapeutic needs. She might get herself to identify with the patient’s sadistic pleasures in the violence.

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and destruction exploding around them, but this felt like a betrayal of herself and of her own experience and values. In her compensatory and exaggerated efforts to be empathic she felt obliterated, while in her fantasized expression of authenticity she risked annihilating her patient. The ostensibly contradictory options amounted to the same thing: dominate or be dominated, terrorize or be terrorized, kill or be killed; in each instance, someone is obliterated. Attempting to alternate between these two positions inevitably left her off balance and confused. She was trapped in this ‘complementarity’ where either option, empathy or authenticity, was the simple inverse of the other. The feeling that we must either submit or resist is the hallmark of the doer-done to relationship (Benjamin, 2005). Here, the supervisor, as so often happens in psychoanalytic supervision, acts as a third to the analytic dyad. My interventions opened up a third perspective, until then unavailable to the dyad. My nudging the compass needle, which had become stuck between opposing binary poles, freed it up to swing to alternative positions, creating space with potential for multiple positions where previously there had been only a simple line between two fixed points.

Once in touch with the patient’s chronic fear and internal battle, with the relief provided by the external concretization of his anguish, the supervisee no longer had to choose between victim and victimizer, between a sadistic and masochistic response, between doing or being done to, between empathy and authenticity. A third option reconfigured her experiential organization. Until then, patient and analyst had been caught in an extreme moment of negation where the acceptance of one person’s subjectivity meant an obliteration of the other’s. In Benjamin’s words, they had become ‘thrown onto the axis of reversible complementarity, the seesaw in which our stances mirror each other’ (1999, p. 203). There must be a move beyond this power struggle to a level of metacommunication that allows the dyad to return from complementarity to mutuality and recognition. What Benjamin and I (Aron and Benjamin, 1999) attempted to theorize was a point of thirdness that allows the analyst to restore a process of identification with the patient’s position without losing her own perspective, to move beyond submission and negation, thus reopening intersubjective space.

I also found the psychoanalytic understanding of the conflicts of identification posed by the primal scene to be helpful to me in understanding the reactions of this patient and analyst. This is not in any way to reduce the horrors of 9/11 to infantile fantasy, but rather to gain an understanding of the conflicting reactions which require management when bearing witness to trauma. It is as if the patient had gone from containing a chaotic, violent primal scene being fought out within his own mind to becoming a witness to such a primal scene but now as an observer struggling to maintain an identification with only one party to the scene. His therapist, in turn, had become caught up in observing the same external scene and may similarly have struggled to contain her own terror by identifying rigidly with the other actor in the scene. One aspect of experiencing unconscious resonances of the primal scene is the intense conflict concerning with whom to identify, and we often manage such conflict by rigidly identifying with one actor and disidentifying with the other. This is perhaps the central conflict with which people struggle in witnessing the primal scene.

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I have previously (Aron, 1995) elaborated on Britton’s (1989) suggestion that the child’s management of the primal scene facilitates the creation of a ‘triangular space,’ which allows for the possibility of being a participant in a relationship and observed by a third person and of being an observer of a relationship between two other people. To clarify this, simply think of the child at one moment looking on at the two parents acting in relation to each other, leaving the child as the excluded third, and then imagine the next.
moment when the child is interacting with one parent while the other parent is left out or looking on. The child oscillates between moments of observation in which he or she is left out of some dyadic activity, and other moments of active participation as part of a dyad, where someone else is excluded. Here is the way Britton described it:

The closure of the oedipal triangle by the recognition of the link joining the parents provides a limiting boundary for the internal world. It creates what I call a 'triangular space'—i.e., a space bounded by the three persons of the oedipal situation and all their potential relationships. It includes, therefore, the possibility of being a participant in a relationship and observed by a third person as well as being an observer of a relationship between two people.

(1989, p. 86)

The Oedipus complex entails not just the child's viewing the parental relationship from the perspective of an excluded outsider; it entails the myriad phantasies of the child in which the entire system of family relations is experimented with and internalized. The little boy or girl is at one moment the small, excluded child barred from the gratifications of adult sexuality; at another moment the same child is the phantasised rival of the father for mother's love, and at the next is seeking a separate, private, and exclusive relationship with the father. The child alternates between seeing himself or herself as an outside observer of a two-person relationship consisting of the mother and father, and then as inside a two-person relation while being observed by a third, the excluded parent. Thus, it is in the oedipal stage that the child first alternates between observation and participation within what is now conceived by the child as a triangle. This fact is clinically important because this oscillating function is the basis from which a person can participate in an analysis as it is through this route that we learn to alternate among a variety of perspectives or vertexes. Benjamin and I (Aron and Benjamin, 1999) argued that important varieties of triangulation take place pre-oedipally as well, and that thirdness already exists within the mother-infant dyadic unit (a point I will return to soon). Nevertheless, I believe, along with Britton, that significant transformations take place at the oedipal level that contribute to our capacities for reflexive self-awareness and lead to qualitative advances in intersubjectivity. While there is a pre-oedipal history of oscillation and participation, it occurs and is experienced as a series of dyads, rather than being integrated into a triangular system.

The work of the Lausanne Group requires a reconceptualization of some of these assumptions. Fivaz-Depeursinge et al. (2004) have been investigating threesome intersubjectivity in infancy. They differentiate 'triadic' interactions between two people about a non-human object and 'triangular' interactions between three people. But the third as elaborated by the Lausanne Group is neither necessarily another person nor an object but rather a third focus within a dyad. Fivaz-Depeursinge and her colleagues have found that the triangular capacity is already in evidence at 3 and 4 months of age. At this early age, triangular relations are immediate and context-dependent. By 9 months they exhibit the beginnings of an intentional stance, and with the advent of symbolic thought and the moral emotions they gain self-reflexivity. It may turn out that primary triangular processes exist from very early on in life and that what is most characteristic of the oedipal stage is not triangularity per se, but rather symbolic thought, narrative structure, and reflexive self-awareness (for a similar examination of the implications of this research, see Stern, 2004, pp. 98-9).

To recapitulate: dyads, couples, and systems tend to get stuck in complementary relations. This complementarity is characterized by a variety of splitting in which one side takes a position complementary to—the polar opposite of—the other side. If one is experienced as the doer, then the other becomes the done to (Benjamin, 2004a); if one is the sadist, then the other becomes the masochist; if one is the victim, then the other becomes the victimizer; if one is male, then the other becomes female; if one is active, then the other becomes passive. Polarities are split between the two members, and the more each one locks into a singular position, the more rigidly the other is locked into the opposing, complementary position, thus heightening the splitting and tightening the polarization. At any time, the split may be reversed without significantly changing the structure of the complementarity. The active member may suddenly become passive while the passive member becomes active, thus their surface roles are switched, but the dyadic structure remains split between activity and passivity. Benjamin has analyzed this manifest exchange of roles without a change in the underlying relational structure, demonstrating that it constitutes a simple reversal which maintains the old opposition (1988, p. 223). Her initial work in this area developed in the context of her study of gender relations and especially in analyzing relations of dominance and submission and the structure of sadomasochism. In later work, she expanded and further developed these understandings, applying them to a variety of clinical and social contexts.

In the clinical example that we are discussing, the analyst experienced the patient as aggressively identified with the terrorists, now terrorizing her and hijacking the analysis. She did not want to submit to this terrorization but felt done to, locked into a victimized
position rationalized by her sense that she was 'supposed to' empathize with and understand her patient. She was locked into a structure she could not escape, so was then tempted to attack her patient in return. She could confront him or intervene in a manner that would challenge his sadism, but in the very act of doing this she might become the active, sadistic terrorist pushing him into the role of the passive, masochistic victim, hence achieving only a simple reversal.

Let's examine the structure of complementarity and the related conceptualization of thirdness. Drawing on Britton (1989) and Benjamin (2004a), I would like to use very simple mathematical ideas (like the third) to explain the structure of this complementarity. I do not use these terms to appear scientifically precise or to quantify these conceptual ideas; rather, these simple geometric terms are useful to me clinically in that they provide a clear, elegant model of therapeutic impasses and how to transform them.

The structure of complementarity is best thought of as a straight line (remember the image of the compass needle stuck between two fixed points). A straight line has two end points opposite to each other. The line has no space; it exists in two dimensions only. You can move only forward or backward along the line but you cannot step outside of that line since it exists in only two dimensions and there is therefore no lateral space. For a couple, a therapist and patient dyad for example, this means that the structure of complementarity keeps them locked into a relational positioning in regard to each other so that one member is diametrically opposite to the other in some significant respect and that there is no way to move or rearrange this structure other than to move toward each other, closer, or to move away from each other, more distant, or to implement a simple reversal and to flip the line around and reverse polarities.

A useful image here is the seesaw. Think of two people on a seesaw where one is on top and one is below. As long as they want to stay on the seesaw, the choices are either moving toward each other or further back toward the edge of the seesaw, thus slightly adjusting their relative power on the fulcrum. That is the only kind of movement possible without getting off the seesaw. Picture this. One is up high, the other is way below. They can maintain their positions or they can switch, creating a simple reversal. But the underlying structure is maintained; they are still on a straight line in which one's position on the seesaw determines the other's. It is possible that each could be in a middle position, sitting evenly or level on the seesaw. But while this seems like an improvement—a more egalitarian, level relationship—it maintains the same structure of rigidity. It remains a single line with the two participants opposite each other and one's position fully determining the position of the other. They remain locked into one pattern of relating. They cannot both be up or down together and one's push downward continues to pressure the other to swing upward. This is the model Benjamin (2004a) developed of complementary, doer-done to, push me-pull you relations, and it elegantly depicts what happens in therapeutic impasses and stalemates.

Another image that metaphorically captures the rigidity of complementarity is the fixed pendulum. In describing chaos theory as a model for a relational developmental theory, Harris (2005) utilizes the fixed pendulum as a model of a rigid attractor. She contrasts the rigid, change-resistant qualities of the pendulum to the less predictable strange attractor which is always on the edge of chaos, a state that can be disequilibrated and then reorganized in unexpected ways. The image of the fixed pendulum is similar to the seesaw and it captures the experience of therapeutic impasse and reversible complementarity described by Benjamin in that it only moves from one side to the other, back and forth, without any of the freedom, flexibility, and unpredictability needed for a relationship of two autonomous individuals interacting in a system of mutual recognition of independent subjectivities.

So how does one move from the structure of complementary relations to a more flexible arrangement? The two participants must find a way to go from being positioned along a line toward opening up space. I am referring, of course, to psychic space, transitional space, space to think, space to breathe, to live, to move spontaneously in relation to each other interpersonally. The conceptualization of the third attempts to model this state in that a line has no space, whereas a triangle does. Britton (1989) spoke about being able to free himself to think to himself while with a patient, to take a step to the side within his own mind so as to create mental space. Picture this literally in terms of geometric space. While on a seesaw, one literally cannot take a step to the side; moving sideways is just not an option. As soon as one can take a step to the side, one has transformed a line into a triangular space with room to think and to relate. One has created options enabling the two members of the dyad to position themselves with some degree of flexibility and freedom of movement. One's position within triangular space does not completely determine the position of the other as it does on a seesaw.

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One significant consequence of being stuck on a straight line in complementary twoness is that the line represents an unconscious symmetry (Benjamin, 2004a). Both partners on the seesaw mirror each other inversely; they are flip sides of each other; they inhabit reversible perspectives. This structural arrangement captures the mutual experience of their deep, generally unconscious, identification with each other. While each partner plays out one side, both of them identify with both positions. We know that the sadist identifies with the masochist, and vice versa, even if these identifications are repudiated in consciousness. Thus, when patient and analyst get stuck in complementarity, even while each feels ‘you are doing this to me, you are forcing me into this position,’ there remains a deep connection between them because they unconsciously recognize that they are locked together in this binary relation, however polarized.

Again, let’s return to my supervisee and her patient. When she could begin to think about her situation, she could see that he was not all sadistic terrorist but also terrified hostage. When she could begin to think about herself and realize that she was locked into identification with the victims, then she could begin to imagine other parts of herself, other identifications, say for example with the power of the terrorists. Once she could take a step to the side, outside of the ‘push me-pull you’ tug of war with her patient, then other relational positions became immediately available to her. Thinking and feeling within the newly created triangular space allowed her to shift from the limiting structure of a polarizing flat line to a space with possibility and depth. As long as the compass needle was stuck, there was just one line from the center of the compass toward one point on the periphery. Once unstuck, the needle could rotate freely making use of all of the points of reference within the compass. The supervisor, not locked into the established ‘transference-countertransference interlocks’ (Wolstein, 1959, pp. 133-4), helps the analyst to develop some perspective from outside the closed system. A new configuration emerges that presents both patient and analyst with additional options for how they position themselves in relation to each other. Now they are enabled to renegotiate (Pizer, 1998) who they are to each other. Rather than following the rigid and predictable back and forth movement of a pendulum, transference can begin to serve as a ‘strange attractor’ allowing the emergence of surprisingly new configurations and unpredictable interpersonal adjustments.

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What is meant by ‘the third’? The third is a concept that has become popular across a variety of schools of psychoanalysis. It has been developed and extended by some of the leading theorists of psychoanalysis, including Ogden, Green, Benjamin, and a variety of Lacan-influenced writers, but it is often defined ambiguously and inconsistently across schools. For some, the third refers to something beyond the dyad, a context within which we emerge; for others, the third is an emergent property of dyadic interaction, and yet for others, the third is a dyadic achievement that creates the psychic space necessary for reflexive awareness and mentalization (Gerson, 2004; and see the entire issue of the Psychoanalytic Quarterly 73(1), 2004, surveying the topic of the third). Here I will elucidate a variety of meanings of the third, especially as the term is used within the theoretical framework of Benjamin’s intersubjectivity theory.

Benjamin has described a variety of different kinds of thirds, or perhaps different ways of thinking about the third, different aspects of thirdness. Her understanding of the third is embedded within her broader contributions to relational theory where she has elaborated the intersubjective dimension as necessary along with, not as replacing, the realm of the intrapsychic. Here I will clarify what she means by the third and illustrate two main types because I believe that Benjamin’s contributions to intersubjective theory are among the most useful ideas to emerge within contemporary psychoanalysis; ideas with direct and powerful clinical implications which I hope to elaborate and extend (see also Benjamin, 1988, 1990, 1995, 1998, 2004a, 2004b).

Benjamin differentiates between what she calls the one-in-the-third and the third-in-the-one. These conceptualizations are complicated and can be confusing, and it should be noted that these two understandings of or aspects of the third are interconnected. To add to the potential for misunderstanding, Benjamin has used a variety of terms to signify various aspects and dimensions of the third. I am going to explain these terms again and will refer to them with some simplification by utilizing prominent examples of each.

What Benjamin has in mind in speaking about the one-in-the-third (which she has also called the nascent third or the energetic third) is that rhythmic or harmonic element of oneness that is essential to the experience of thirness. It may be more easily understood by calling it a rhythmic third, keeping in mind Sander’s (2002) term, the principle of rhythmicity, or what I would suggest referring to as mutual accommodation. Benjamin very clearly describes this in terms of two people sharing a pattern, a dance, a rhythm with each other. Think of the rhythms established by the mother-infant dyad in eye gaze, reciprocal speech, gestures, movements, and mutual mirroring. In discussing Sander’s work, Benjamin (2002) has usefully described this as resembling musical improvisation, in which both partners follow a pattern that both of them simultaneously create and surrender to, a co-created third. With the phrase ‘the-one-in-the-third,’ Benjamin is trying to capture that experience of oneness, mother-infant oneness or the oneness of a jazz band improvising in synch. Each member is not only accommodating to the other, but is also accommodating to the co-created rhythm that the couple or group has already established. The principle of mutual accommodation thus expands what we know to be ongoing mutual
influence to include not only the ways two people influence each other, but also the ways in which they are continually influenced by the very patterns and rhythms that they have previously established with each other.

It is critical to note here that this form of thirness may well be pre-oedipal, in that it emerges out of the mother and infant's accommodation to each other as well as to their own prior accommodations. This form of thirness does not require an oedipal father to sever the child's connection to mother. In arguing that thirness emerges within the pre-oedipal mother-infant dyad, Benjamin differentiates her ideas from those of Lacan who saw the father as having to symbolize the third. This is not to say, however, that mutual accommodation and rhythmicity do not acquire new meanings and become richer and further differentiated and elaborated during the oedipal and post-oedipal phases. To some degree, it may be that what seems like an argument about pre-oedipal triangularity may be an artifact of differing theoretical, cultural, historical, and linguistic traditions in psychoanalysis. For Lacan and many European analysts, as well as for others who write about the third, such as Green, the mother-infant dyad is always already triadic in the sense that the mother herself is engaged in the symbolic world, thus a third structural element is always already present even if the father himself is not concretely a figure on the scene. Ogden provides a description of the mother-infant dyad that beautifully elaborates on such a position. He writes, 'The paradox of the little girl's transitional oedipal relationship (created by mother and daughter) is that the first triadic object relationship occurs in the context of a two-person relationship' (1987, p. 483). Nevertheless, I want to highlight some of the subtle differences among these theorists. In Ogden's example, it is the mother who contains the third element intrapsychically, while, in the rhythmic third, the thirness is a new creation emerging within the space of the dyad, rather than in the mind of one or the other participants alone.

Now let us take up the other of Benjamin's prominent thirds, the third-in-the-one, which she also calls the symbolic or the moral third (2004a). Benjamin has also suggested the 'intentional third' (personal communication, January, 2005) in order to highlight that this third creates a space for differentiation in what is ordinarily called oneness. Benjamin (2004a) illustrates this principle by referring to the term 'marking' or 'marked response.' The idea of markedness was originally developed by Gyorgy Gergely and is described by Fonagy et al. (2002) where they elaborate a social-biofeedback theory of affect-mirroring. Recent conceptualizations of 'mirroring' emphasize that, no matter how well attuned a parent is to the infant's state, her mirroring facial and vocal behaviors never perfectly match the infant's behavioral expressions. Mothers, and other adults, 'mark' their affect-mirroring displays (that is, they signify that these responses are reflections of the other's feelings rather than being expressions of their own feelings) by exaggerating some aspect of their own realistic response. The mother 'marks' her mirroring response to her child to signal, so to speak, that it is her version of his response. The marking (the exaggerated affect display) is meant to differentiate the response from what would have been her own 'realistic' response. It is markedness that indicates that it is not mother's affect display, but her reflection (her understanding, her version) of the infant's affect. The exaggerated quality provides a personal stamp or signature, signifying that it is not a perfect reflection of the other, nor a completely natural response of the self. The infant recognizes and uses this marked quality to 'decouple' or to differentiate the perceived emotion from its referent (the parent) and to 'anchor' or 'own' the marked mirroring stimulus as expressing or his own self-state. An illustration will help clarify this process.

When a mother sees her young child fall and bruise his knee, she exclaims 'Ohhh' in such a way as to signify her empathy with the child's pain and fear. Nevertheless, the mother is not (or should not be) responding with the same degree of disorganization as her child. She both identifies with her hurt, frightened child and also marks her response (usually by some exaggerated feature) by signifying that she is not reacting exactly as the child is, but that she is separate. In the infant's experience, the parent's mirroring behaviors convey a sense of 'nearly like, but clearly not identical to me.' Nor, however, are they viewed as real emotional expressions of the parent. They are neither realistic authentic responses of the self, nor are they perfectly matched reflections of the other. Emotional attunement, mirroring, and empathy all have built-in elements of authenticity along with reflections of the other. Mirroring, and empathy itself, dialectically contain elements of authenticity and do not wipe out the features of either self or other. It is neither a sadistic destruction of the other nor a masochistic betrayal of the self. Therefore, mirroring, with its marked component, is a dyadic phenomenon, functioning as a differentiating third point emerging between the infant and the attuned parent. Think of the third here, once again quite literally, as constituted by three points: the child's immediate response, the mother's response identifying with her child's fear, and then that more adult, differentiated component of the mother's response in which she knows that the child is not dying and will get over it.

Thirdness thus emerges here from within the dyad without needing a literal third object to intervene and separate mother from child. This is what Benjamin and I (Aron and Benjamin, 1999), describing the origins of self-reflexivity in intersubjective space, called an incipient third. It is in this way that mirroring creates a third symbolic intersubjective space of representation between infant and parent allowing for and facilitating mentalization and affect-regulation. The marked response is thus an excellent example of the

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third-in-the-one or intentional third in that it facilitates the differentiation of the self and other within their very connectedness. It should be clear that this understanding of mirroring is quite different from the classic Lacanian understanding in that in this view of mirroring, the mother is not at all a unitary image providing false imaginary unification, but rather is split between two subjective positions, one aligned with the child and one distinct and marked. This will have clinical implications for the analyst as we will soon see as we turn to examine how the analyst’s mirroring responses provide the patient access to their analyst’s own inner conflicts and double-mindedness.

Recall that Benjamin’s work is to a large extent inspired by the contributions of Winnicott. In an examination of the mirroring metaphor in the history of psychoanalysis, Reis (2004) explains that, for Winnicott, when the mother looks at her infant she identifies with her own experience of being an infant, as well as what it feels like to gaze at her own child. So for Reis—and here he is extending the earlier work of Ogden (1994)—what the mother reflects back to the infant is the experience of sameness within difference. Note here the structure of thirdness, the third-in-the-one. In Reis’s scheme, there is the infant, the mother identified with her own experience of being an infant, and the mother experiencing what it is like to gaze as a mother at her own infant.

The one-in-the-third and the third-in-the-one are interconnected, rhythmicity and markedness go together, with the former emphasizing connectedness and the latter emphasizing difference; each is necessary to the other. Perhaps it is worth highlighting once more that both of these principles of thirdness—rhythmicity and markedness—are found in pre-oedipal mother-infant relations, and that both principles become further differentiated, elaborated and structured during the oedipal and post-oedipal phases. Nevertheless, thirdness itself arises conceptually as independent from oedipal triangulation. The empirical study of early family group relations, relations beyond the dyad that include triadic and familial relations, is itself in its infancy, and further research is bound to clarify the developmental issues surrounding dyadic and triadic social functioning in the pre-oedipal, oedipal and post-oedipal stages (Mclehale and Fivaz-Depeursinge, 1999). Like Stern (2004), I believe intersubjectivity is best conceptualized as an independent motivational system fostering group formation and group cohesion in a hypersocial species; as such, it is most likely innately present in rudimentary form very early in life. From an evolutionary perspective, it is likely that as a social species we would be born with some innate competence to deal with multipartite relationships.

I will now turn my attention to some of the clinical implications of intersubjectivity theory and the notion of the third. One way to understand why contemporary psychoanalysis has become interested in the third is that thirdness is one way to conceptualize reflection and symbolization. It is a theory of thinking that transcends the mind in isolation, a relational theory of symbolization. I want to make the case that certain forms of the analyst’s self-disclosure are best understood as legitimate and at times necessary attempts to create thirdness. By disclosing aspects of their inner processes, particularly their own inner conflict or self-disagreement, analysts conduct a dialogue with themselves in the presence of their patients, thus introducing a third element into the dyad. At times these self-disclosures operate as strange attractors, breaking up the single-lined stuckness of the seesaw and introducing a third dimension, thus creating psychic space for reflexive awareness and mentalization.

Contemporary Kleinians view the third as an oedipal construct, conceiving the third as an aspect of the analyst’s mind rather than a shared co-created experience. From this perspective, Britton (1989) understands his patient as attacking the third in the analyst’s mind because it represents an oedipal rival third that cannot be tolerated. However, by placing exclusive emphasis on the oedipal situation, Britton, like most analysts who have written in this area, bypasses the important forerunner of triangular space that emerges from within the mother-infant dyad.

Britton (1989) presents the case of Miss A to illustrate the patient’s inability to tolerate knowledge of parental intercourse because accepting this triangular relation would entail a threat to an all too tenuous internal and external relationship to her mother. Any attempt on Britton’s part to engage in a perspective outside Miss A’s own was experienced as intensely threatening to her and for a long time resulted in her becoming violent. Gradually, Britton learned to allow an evolution within himself of his own experience while articulating to Miss A his understanding of her point of view, something like what we call mirroring. This progressively allowed Miss A to begin to think. Britton retains the oedipal metaphor and utilizes this imagery creatively, stating that parental intercourse could take place only if the knowledge of it did not force itself in some intrusive way into the child’s mind.

Benjamin and I (Aron and Benjamin, 1999) argued that Britton’s superb clinical sensitivity is better formulated in the following way. Britton constructed a relationship with Miss A in which he reflected back her own point of view as it was inevitably filtered.
through his own thought processes and emotional responsiveness. He successively elaborated his thinking about her point of view in such a modulated manner that she could gradually begin to identify herself with an image of him thinking about her. He thereby created a sense of mutual identification or attunement, which allowed her to gradually feel that the other understood her experience sufficiently well so that his thinking did not replace or supersede hers. His thought became available as an object for her use, facilitating reflection, each person thinking about the other's thought. Thus, he did not intrude as a third element into their dyadic relationship, but, much like in the mother-infant dyad, a third space was jointly constructed out of the dyad. This occurred as Britton began to think about her point of view but inevitably from his point of view, and as she was able to identify with his thinking about her thoughts, thus taking her thinking to a second power.

Britton concludes that, since his patient cannot tolerate the analyst's thinking, which represents the analyst's sexual relation to an oedipal third, all the analyst can do is to allow the evolution within himself of his own experience, to articulate this to himself, while communicating to the patient only the analyst's understanding of the patient's point of view. Britton therefore calls for triangular space to be opened up only in the analyst's mind. But it seems to me that this account really does not explain how this internal thinking in the analyst eventually leads to any shift in the patient. Does Britton mean to suggest that articulating understanding completely from the patient's point of view will eventually allow the patient to tolerate a third perspective? Perhaps. But I would argue that Britton, and all analysts, try as they might to stick with the patient's perspective, to articulate the world as it is experienced by the patient, inevitably introduce some difference, some marking of their reactions as different from the patient's. I would certainly agree with Britton that the analyst's own perspective may have to be offered with great subtlety, marking the response only slightly; nevertheless, at least conceptually, this markedness conveys some degree of thirdness and differentiation and thus gradually creates analytic space (Aron and Benjamin, 1999).

Let us again think in very simple concrete terms about what it is that the analyst is doing. If the analyst is really only thinking silently about the patient in a differentiated way, without conveying any of that to the patient, then how does this create space between them? Sooner or later, at least in some small measure, does not the analyst have to be able to demonstrate to the patient that the analyst can think about his or her own reactions? Does not the analyst have to have some kind of dialogue with him- or herself, something in the form of: 'I am of two minds about this idea, I can hold on to two ideas, two points of view, some conflict or disagreement with myself'? It is the analyst's reflexive self-awareness, a dialogue with oneself, that creates a third point within what was a simple dyad, a triangular space where there was only a line.

Asuperb account of this clinical process is 'the dialectics of difference' described by Bollas (1989). Bollas encourages the analyst to differ with him- or herself, to express some conflict, for example, about making a particular interpretation, or to explain to a patient something of the internal process that led to arriving at an interpretation. Bollas might disagree with himself, for example, saying to a patient that he feels his last interpretation was not quite right and here is why. Bollas advocates this form of self-disclosure with the intention of helping the patient to gradually accept and articulate conflict of his or her own.

Similarly, Hoffman (1998) advocates that analysts may at times reveal various conflicts about their analytic functioning. He offers numerous examples along the lines that he would like to say X but he is worried about Y. For example, he tells one patient that he would like to offer her support about a particular activity but he worries that offering such support will encourage her dependency. Numerous analytic authors have argued for some increased acceptance of the analyst's self-disclosure, emphasizing a variety of rationales for this hitherto discouraged technical option (see my review of Bollas, Hoffman, and the topic of self-disclosure, in Aron, 1996).

Yet another clinical theorist who articulates a rationale for some increased sharing of the analyst's inner workings is Bach (2003). In the following passage, note how Bach, just like Bollas and Hoffman, advocates not only analysts sharing with patients the inner workings of their minds, but also very specifically emphasizes the importance of analysts disclosing certain aspects of their own double-mindedness, ambivalence or inner conflict.

I try, whenever possible, to explain the reasoning behind my comments and interpretations and, better yet, I allow the patient to witness my mind at work in the process of free-associating or making formulations, so that the interpretation becomes a mutual endeavor and is thereby much improved. It is especially useful for such patients to experience the analyst as he tries to deal with doubt and ambiguity, or as he tries to hold two ideas or two roles in mind at the same time, for it opens up the possibility of their doing the same. Most importantly, since I am implicitly asking my patients to trust me with their minds, I struggle to attain a position where I can trust them with my own mind and feel that I have nothing to hide from them.
Here is one further clinical illustration from the work of McLaughlin (2005). McLaughlin, a seasoned analyst, was working with Mr. F who was engaging in high-risk sexual encounters during the early years of the AIDS epidemic. McLaughlin tells the story of how closely he came to being pushed beyond his personal and analytic tolerance. In spite of his best efforts to remain neutral and non-intrusive and to refrain from imposing moralistic or overly protective restraints in regard to Mr. F’s anonymous homosexual encounters and cruising, McLaughlin could not conceal from his patient his own aversion and his wishes.

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to restrain his patient. McLaughlin beautifully describes the resulting impasse between him and Mr. F as well as his personal struggles to see the situation from Mr. F’s perspective and his own deep self-analytic efforts. Ultimately, for Mr. F the difficulty was not McLaughlin’s concerns but rather his ‘dissembling,’ his lack of directness about his feelings. Having arrived at this understanding, McLaughlin was able to directly disclose his own conflict to Mr. F. ‘I was able then to speak about the quandary of my wish to urge him to do the sensible thing, countered by my concern for his need for autonomy’ (p. 220). It was this collaborative work and direct acknowledgment of the analyst’s conflict that led to the resolution of the dangerous cruising behaviors and the associated analytic impasse.

In my view, the understanding of thirdness as central to intersubjectivity provides the single best explanation for the clinical importance of certain types of self-disclosure as well as for understanding its limits and boundaries. The technical interventions described by Bollas, Hoffman, Bach, and McLaughlin may be creatively explained using Benjamin’s and my own elaboration of the notion of the third. Bollas’s description of the dialectics of difference; Hoffman’s clinical examples of revealing some aspect of his own conflict to a patient; Bach’s argument for allowing a patient to witness his own mind at work especially in regard to keeping two ideas in mind; and McLaughlin’s sharing with Mr. F his own quandary in conducting his treatment may each be seen as various ways to begin to create analytic space by bringing in a third point of view. By disclosing their own difference with themselves or conflict or double-mindedness, what they are doing is saying, ‘I am of two minds about this intervention.’ They are saying, ‘OK, there are at least three of us here. There is you and then there is the I who wants to support you, and the I who is afraid of encouraging your dependency.’ Or they are saying, ‘There is the you who heard my last interpretation and felt whatever you felt, then there is the I who said it, and the I who now disagrees and feels somewhat differently.’ In the examples provided by Bollas, Hoffman, Bach, and McLaughlin, it is the analyst who goes first, in the sense that the analyst feels free to own his or her own conflict or inner difference before the patient is expected to do so. Similarly, Benjamin (2004a) argues that, in an impasse that is structured along the lines of complementary twoness, of doer-done to relations, analysts may have to go first revealing their own vulnerability before expecting this of the patient. It is not simply a matter of going first in the sense of sequence, rather, it is a matter of the analyst taking responsibility for participating in the push-pull by having said or done something that contributed to it. This relates to the all-important recognition that enactment and co-participation are essential and facilitative aspects of the analytic process. This does not mean that just any self-disclosure is clinically productive or that the analyst should just speak his or her mind or that anything goes—obviously not. The analyst’s response must be marked, it must in some small way differentiate itself from the patient’s response (the differentiating or intentional third or markedness), yet it also must reflect the analyst’s accommodation to the needs and perspective of the patient as well as to the various accommodations, rhythms, previously established between them (the rhythm third as mutual accommodation and negotiation).

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To return to my initial clinical example, suppose the analyst could find a way to say something to the patient about her understanding of how his excitement about the attacks was understandable because it could feel so exhilarating to see the violence out there in the world, outside of himself; to identify with the excitement of having that much impact and control of the whole world. This could be said in a genuine way, by which I mean that the analyst could genuinely identify with the power and the excitement of the power, without losing her own sense of the horror of the destructiveness. I think, however, that to say this would not simply be a mirroring of the patient’s affective state, but rather would include inevitably some markedness, some difference between the reaction of the patient himself and what is captured by the analyst’s interpretation. This very point of difference leaves open an invitation to the patient to correct the analyst, to dialogue with her about the difference between his lived experience and what is captured by her remark, as well as negotiate the meaning of these experiences between them. Clearly, neither empathy nor negotiation is a steady process, rather, intersubjectivity is constructed and lost, ruptured and repaired (Beebe and Lachmann, 1994). This very process of rupture and repair may be well understood as drawing on the power of the third, the dialectic, or put another way, the negotiation of...
difference.

But consider another intervention. I could also see the analyst saying to the patient something along these lines: ‘Oh I see, I was missing something. I was so appalled by the violence and so saddened by the loss of life that I didn’t want to let myself see that I also felt some excitement by the very power involved in the horror.’ Would it really be so surprising if following an intervention like this the patient could begin to notice that he also had more than one set of feelings about the disaster? Might not the patient react with something like: ‘Oh, you mean you can actually find the aggression exciting too? Can you at times really feel pleasure at innocent people’s death the way I can?’ The answer to this question, whether articulated to the patient or not, would be: ‘Yes, I can feel such excitement, and it is so appalling to me, so frightening to let myself feel such sadism that I’d rather be repulsed by it in you than recognize and acknowledge it in myself.’ The analyst here is taking a step to the side; she is beside herself, dialoguing with herself, thinking out loud. Where until now there has been a simple line with patient and therapist at opposite ends, there is now triangular space with some increased room to move. As Benjamin has written in commenting on the work of Davies,

in order to speak about the coercive, hateful, or destructive aspects of the relationship, there must be a shift from destructive, table-turning tit for tat into the mode of feeling free to tell it like it is, to own up to feelings.

(2004b, p. 744)

As this illustration makes clear, I do not think of the third as describing a kind of analytic space that exists free of enactment. As Davies (2004) very usefully clarifies, the third does not re-establish a form of objectivity free of distortion and co-participation. Rather, it is one step in an always shifting dynamic process, an effort to create a psychic space within which to think together about ways in which patient and analyst are similar and different, merged and separate, identified and differentiated from one another. We should not expect the third to be a stable or

static achievement. The nature of thirdness is that it is an ever-shifting, dynamic process. Intersubjectivity consists of a dialectic process of mutual recognition and breakdown into complementarity.

The conceptualization of thirdness presented here clearly rests upon the assumption that transference and countertransference constitute an intersubjective dyadic system in which both continually influence each other and must be resolved in relation to each other. Exploring the nature of therapeutic impasses and treatment plateaus, as long ago as 1959, Wolstein defined what he referred to as ‘transference-countermference interlocks’ (pp. 133-4). Wolstein, whose writing was dense and abstract, was a leading clinician and theoretician within the interpersonal tradition, and his work is therefore hardly known among analysts of other schools or for that matter outside of New York where he taught and practiced. Wolstein's early portrayal of analytic impasses is remarkably similar to what Benjamin and I have described in our work on the third. Wolstein argued that, in these situations of interlock, transference and countertransference automatically emerge in correlation to each other's development. In situations of interlock, in that area or dimension where the two co-participants are stuck, ‘neither participant is capable of free and independent movement’ (1959, p. 135). Indeed, Wolstein used the same figures of speech that Benjamin and I have been using, speaking of the ‘reactive kind of push-and-pull cooperation’ (p. 137) and of transference and countertransference as ‘interpenetrating’ (p. 141). Over and over again Wolstein points out that the end result of these interlocks is either that the patient finds a way to leave, or the analyst gives up, either by coming to the conclusion that the patient is too disturbed or unanalyzable or by literally ending the analysis. The alternatives to this bleak ending involve either the analyst getting supervisory help by going to a third party, a consultant or analyst, or, preferably, the analyst turns to the one person who is in the best position to make observations about the countertransference, namely, the patient.

In opening him- or herself up to exploring the countertransference by attending to the observations of the patient, the analyst can transcend the dualism that structures the interlock. While not literally utilizing the language of the third, Wolstein anticipated and influenced much of the contemporary interpersonal and relational focus on the interplay of transference and countertransference, mutual enactments, mutual influence, and the intersubjective third. Just as Benjamin and I have placed special importance on the need for analysts to acknowledge their role in creating the impasse, and just as contemporary analysts have emphasized many mutual processes in psychoanalysis (see Aron, 1996), so too Wolstein wrote:

Once an interlocking of transference and countertransference sets in, the analyst may be said to need his patient's recovery because, in a sense, his own is actually involved. It is not simply a matter of invested time and energy; instead, a real opportunity for personal growth is at stake. This is the crucial dynamism in the experiential field that works toward a therapeutic outcome: both the analyst and his patient have now to find a way to a level of relatedness and integration that will be richer and more meaningful than the one they are capable of at this point.

(1959, p. 169)
Before ending with another everyday clinical example that illustrates the practical usefulness of thinking in terms of the third, first I want to introduce Gentile's

(2001) penetrating discussion of the origins of intersubjectivity. Gentile re-examines Winnicott's theory of transitional space by elaborating on several contemporary psychoanalytic theories of the third. She demonstrates that Winnicott never fully developed his conception of intersubjectivity or integrated it with his ideas about transitional space. Symbolic space exists as a third to the dyad, and intersubjectivity is predicated upon transitionality, a space that lies at the crossroads of subjective and material life. Gentile highlights how the creation of the transitional object involves the paradox of surrendering to the unyielding aspects of materiality while simultaneously transcending it through imagination and omnipotent subjectivity. Interpretive space is opened between the symbol and the symbolized, between brute reality and subjectivity. Brute reality and materiality is given meaning and is thus transformed.

If materiality is one, and omnipotent fantasy is second, then meaning and symbolic space are the third. Consider the following everyday clinical illustration. A patient arrives some minutes late to a session and explains that the New York City subways were once again late. She had given herself plenty of time had only the trains been reasonably on time. The patient, however, may go on to blame herself. Of course it was her fault. She should have anticipated the delayed train schedule and left even earlier; it must have been her own resistance. She's not motivated enough, not a good enough patient. Now, of course, the analyst too can become caught up in one of, or alternate between, these two positions, blaming or excusing the patient. The analyst may alternate between wanting to interpret the patient's resistances to the treatment and wanting to interpret the patient's omnipotence in thinking that she can be and should be in such total control of all contingencies. Too often these polarities are enacted between patient and analyst on the seesaw of the transference-countertransference where one party embodies the accuser and the other the defender, one championing omnipotence and one surrendering to forces beyond one's control, or, in traditional terms, one interprets and one expresses resistance. This back and forth, mutual projection of accusation and defense, interpretation and resistance, resembles the rigid attractor of the fixed pendulum. Here patient and analyst can so easily become locked into a stalemate or impasse.

But consider now what happens when the patient and analyst can play with the fantasy that the patient could control the timing of the trains, when the patient can joke about how she so wanted to come late that she wished the trains were delayed or calculated arriving just after the last train left the station. The patient needs to be able to do this lightly, not sarcastically or cynically or masochistically, moving beyond surrender to the objective facts or omnipotent control of reality to play in transitional symbolic space. Only with third possibility, when the patient can entertain the fantasy that she purposefully made the trains late, without getting caught up in exonerating herself by pointing to the concrete unavoidable realities and also without becoming trapped in omnipotent, masochistic self-blame, guilt and shame—only then can she utilize her free associative skills that permit the growth of mentalization and symbolization. This is the structure of analytic symbolization.

Let me elaborate several extensions of this illustration. Instead of a late train, consider a patient's playing with getting a cold that keeps him from attending a

session, or a young single woman exploring why she never meets eligible men, or a man wondering why he repeatedly ends up working for demanding and authoritarian bosses, or another patient wondering why he always seems to find therapists who get bored and sleepy with him. In each of these instances, both the patient and the analyst can easily fall into the following two positions: in position one, they each may hold the patient responsible, highlighting the patient's agency but perhaps reinforcing omnipotence and masochism; in position two, they each may exonerate the patient of all responsibility, emphasizing material reality and the patient's acceptance of what is beyond their control. Or, as is so commonly the case, the patient and analyst may alternate between these two polarities in a series of simple reversals. Only when they are both able to achieve a third position, transcending the first two, have they moved beyond sadomasochism, beyond a transference-countertransference interlock, and beyond binary thinking into the transitional, symbolic space of thirdness and intersubjectivity.

Psychoanalysis has been plagued by its preoccupation with binaries, polarized between theorists and schools that emphasize drive or culture, self or object, attachment or separation, autonomy or relations, the individual or the social, the intrapsychic or the interpersonal. In our own dialogue and development, we as psychoanalysts become stuck in impasses and stalemates, locked in heated battles between representatives of these polarized positions. Each theorist or school stares across the divide into its mirror image, locked in complementarity. Conceptualizing the third is one attempt to move beyond such oppositions and to create triangular space within which psychoanalysis too can think more freely, open dialogue, grow, and develop.
Translations of Summary

Analytische Sackgasse und das Dritte: klinische Implikationen der Intersubjektivitätstheorie. Dieser Aufsatz untersucht das Konzept des Dritten im Rahmen der modernen Intersubjektivitätstheorie. Um dieses häufig missverstandene Konzept auf eindeutige und benutzerfreundliche Weise zu erklären, werden mannigfaltige Metaphern benutzt (das Dreieck, die Wippe, seltsame Attraktoren [Fraktaltreiber] und der Kompass). Es wird die These vertreten, dass die Intersubjektivitätstheorie unmittelbare Implikationen für die klinische Praxis besitzt und dass das Konzept des Dritten besonders hilfreich ist, wenn man verstehen möchte, was in klinischen Sackgassen geschieht und wie man zu einer Lösung kommen kann. Der Autor vertritt insbesondere die Ansicht, dass bestimmte Formen der Selbstreflexion am treffendsten als Versuche verstanden werden, einen dritten Bezugspunkt zu setzen und auf diese Weise psychischen Raum für Selbsterfahrung und Mentalisierung zu schaffen. Ein klinischer Fall sowie eine Reihe kürzerer Illustrationen demonstrieren die theoretischen Konzepte und verweisen auf spezifische Modifizierungen in der Haltung des Psychoanalytikers, die dem Patienten einen besseren Zugang zu der Denk- und Empfandungsweise des Analytikers geben. Dies führt ein Drittes ein, das es ermöglicht, von einer komplementären Beziehung zur Gemeinsamkeit zu finden.

El impasse analítico y el tercero: implicaciones clínicas de la teoría de la intersubjetividad. Este artículo revisa la noción del tercero dentro de la teoría contemporánea de la intersubjetividad. En un esfuerzo por explicar de manera clara y fácil este concepto a menudo mal comprendido se recurre a una variedad de metáforas (el triángulo, el serrucho, los atracadores extraños y el compás). Se trata de demostrar que la teoría de la intersubjetividad tiene implicaciones directas para la práctica clínica, y que la noción del tercero es particularmente útil para la comprensión de lo que sucede y para la solución de situaciones de impasse y estancamientos clínicos. El autor sugiere específicamente que ciertas formas de self-disclosure constituyen en realidad un intento de crear un tercer punto de referencia, que abra un espacio psíquico para la autorreflexión y la mentalización. Se presenta un caso clínico como también varias viñetas breves para ilustrar los conceptos teóricos y para sugerir modificaciones específicas de

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la actitud del psicooanalista que dan al paciente mayor acceso a la elaboración interna de la mente del analista. Esto introduce un tercero que facilita la transformación progresiva de relaciones de complementariedad en relaciones de mutualidad.

L’impasse analytique et le tiers: Implications cliniques de la théorie intersubjective. Le présent article examine la notion de tiers à travers la théorie intersubjective contemporaine. Une série de métaphores sont utilisées (le triangle, la balançoire, les acteurs étrangers, le compas), dans le but d’expliquer de façon claire et facilement utilisable ce concept souvent mal compris. L’argumentation prend appui sur le fait que la théorie intersubjective a des implications directes dans la pratique clinique, et que la notion de tiers est particulièrement utile à la compréhension de ce qui arrive lors de la résolution de situations cliniques se trouvant dans la stagnation ou l’impasse. Plus spécifiquement, l’auteur suggère que certaines formes de « dévoilement de soi » ("self-disclosure") sont mieux comprises comme des tentatives pour créer un point de référence tiers, en ouvrant ainsi un espace psychique pour l’auto-réflexion et la mentalisation. Un cas clinique, ainsi qu’une série de brèves illustrations, sont fournies afin de mettre en évidence les concepts théoriques et de suggérer des modifications spécifiques de la position psychoanalytique, qui permettent au patient d’avoir un plus grand accès au travail interne de l’esprit de l’analyste. Ceci introduit un tiers qui permet la transformation des relations de complémentarité à des relations de mutualité.

Impasse analítica e il terzo: implicazioni cliniche della teoria intersoggettiva. Questo articolo esamina la nozione del terzo in rapporto alla teoria contemporanea dell’intersoggettività. Vengono utilizzate varie metafore (triangolo, dondolo a bilico, attrattori strani, bussola) al fine di spiegare in modo chiaro e semplice questo concetto così spesso mal compreso. Si cerca di dimostrare che la teoria intersoggettiva influenza in modo diretto la pratica clinica e che la nozione del terzo è particolarmente utile per la comprensione e la risoluzione di impasse cliniche e situazioni di stallo. In particolare, l’autore avanza l’ipotesi che alcune forme di autosvelamento costituiscono in realtà un tentativo di creare un terzo punto di riferimento che apre uno spazio psichico in grado di promuovere autoriflessione e mentalizzazione. La presentazione di un caso clinico e di alcuni più brevi esempi serve per illustrare i concetti teorici. Vengono inoltre dimostrati i benefici per il paziente di determinate modifiche della posizione dell’analista che offrono un maggiore accesso alla mente e al pensiero di quest’ultimo. Si introduce in tal modo la nozione del terzo che consente la trasformazione di una modalità di rapporto di complementarietà in relazioni di mutualità.

References


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