
Psychoanalytic Dialogues, 14:733-741

Relationships to Bad Objects: Repetition or Current Self-Disorganization?
Commentary on Paper by Jody Messler Davies

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The authors conceptualize Davies's account of the difficult session with her patient Karen as a mentalization mismatch: an expectable failure on the analyst's part to understand the mental state of the patient. In response, the patient used projective identification to re-create the link to the analyst that was temporarily severed. They argue that the therapeutic impasse produced by Karen's successful externalization of a persecuting part of her self is more than repetition of a past relationship. It is the current experience of a disorganized self: a pervasive state for the borderline patient, and a temporary but no less disorganized state in the analyst.

It is now Saturday. The weather has improved, as has Jody Davies's cold. She has had an opportunity to reflect on the events of that gray Thursday afternoon. This is the third day, the third position. Davies's paper is highly successful in drawing our attention to the sheer impossibility of apprehending, let alone appropriately responding to, the complexity of unconscious communication between patient and analyst in a single session. Davies's self-disclosing and painfully honest reporting of her state of mind inspires awe and deep gratitude. Her eloquent and unforgettable delivered plenary address moved a conference audience of more than a thousand. Her paper is brimming with ideas, and our challenge in discussing them is to choose between the many lines of thought that her paper has stimulated.

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In this commentary, we concentrate on the clinical process described in the report. Davies's paper begins and ends in the consulting room. Karen, a traumatized woman with a cruel streak that Davies knows well, lived up to Davies's expectation that Karen would capitalize on the temporary weakness of her analyst. The session unfolded in a most interesting way that is worthy of review, because it so powerfully illustrates the conceptual contributions of the paper.

Karen attacked the analyst for her continued illness. The impression is that Karen experienced the analyst as having let her down by not being well. Having noticed her patient's increased body tension, Davies anticipated a challenge that did arrive: a demand for a demonstration of commitment that clashed with the analyst's prior commitments to her family and other patients. As Davies was aware, the patient at this moment was developmentally functioning in what we have called a "psychic equivalence mode" (Fonagy et al., 2002), perhaps triggered by concerns about her analyst's illness. At that moment, Karen was frightened illness had taken away the person who had had her in mind, just as illness had affected her mother. Temporarily, Karen lost past images of a Davies who was thoughtful and caring about her feelings. Unable to retain a mentalized (psychically functioning) image of her analyst, Karen was forced to substitute an observable action (the analyst's changing the time of her session) for the image of Davies in a caring state of mind. Perhaps the past history of unprovoked attacks by Karen biased Davies. She could not see the understandable fear that being with a sick analyst will inevitably cause in a patient with Karen's history. We know that at a certain point Karen lost her mother's attention to paralyzing depression. We can imagine that her analyst's illness repeats or triggers some part of the emotional trauma that surrounded that experience.

The analyst, feeling sick and beleaguered, found herself giving information that was not requested or necessary. She was probably unconsciously aware (as suggested by her sudden focus on her body) that the patient had temporarily lost psychological contact with her. Davies felt the need to recover the relationship and reached out to Karen. She told her that she really regretted not being able to meet the demand that Karen presented: "I so wish that I had a time ..." Karen did not feel that her anxiety about her analyst's state was understood. Her fear was not mentalized. In addition, she was probably not convinced that the analyst truly did wish that she had time. Karen felt misperceived and perhaps responded to in a nongenuine way, and

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what was said reinforced her fear that she was in a room with an object who had—for the moment—lost her capacity to comprehend. And, being unseen, her fragile sense of herself felt at real risk of dissolution. As Davies recognized, Karen then had to defend herself against her vulnerability: she launched a venomous attack.

Davies's beautiful description of this therapeutic impasse, together with her theoretical commentary, highlights for us the key elements that contribute to such stalemates, all too common in our work. The start is a mentalization mismatch: an expectable failure on the analyst's part to understand the mental state of the patient. The patient's understandable response of withdrawal to this intensifies the attachment response of the analyst, leading to exaggerated caretaking behavior. This is the moment of danger where the analyst often overreaches toward the patient (in this instance: "I so wish I had a time ... "). In response, the patient uses projective identification to recreate the link to the analyst that was temporarily severed. In this context, it is helpful to see projective identification in the traditional sense of Melanie Klein's (1946) definition. This was formulated by Laplanche and Pontalis (1973) as a "fantasized projection of split-off parts of the subject's own self ... into the interior of the mother's body, so as to injure and control the mother from within" (p. 356). Projective identification entails an action of one of the participants in the therapeutic dyad aimed at recreating the link—the lost bond of understanding—to the other, an action that places a thought from the self into the mind of the other. The specific action (such as attacking the analyst for her ungiving meanness), which often mistakenly (but not here) becomes the focus of interpretive work, is actually of little significance. What is significant is the impact that the patient imagines that the action created. He or she expects to force the analyst to think about what he or she (the patient) is thinking, and this sharing of mental waters re-creates the temporarily lost connection. Here, we are not concerned with Klein's preoccupation with injury, aggression, death, and destruction. Where Klein's thinking is most helpful is in identifying that the major function of projective identification of this kind is to re-create a lost interpersonal bridge.

In this instance, Karen—perhaps under internal pressure or sensing a distance from the analyst—externalized a persecuting part of the self and closely observed the analyst for evidence of the projective process. If such an externalization is successful, as in this case, it reassures the patient about the presence of the link. Karen's secret

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smile, noticed by Davies, signaled that her unpleasant behavior was sufficient to recreate in Davies the unbearable critic that Karen experienced within. The unfolding of this session illustrates the continuation of this dynamic, which paradoxically helped Karen to continue to feel some satisfaction. The analyst's withdrawal, frightening and painful as it probably was, assured Karen that the hostile, ungiving, uncomprehending figure was inside her analyst and no longer in her. She did not then necessarily wish to remain in the presence of this torturing figure; she might have been only too pleased to be free of it. Davies's remarkable clinical skills are apparent as she identifies clearly the subjective situation that existed in Karen's mind: Karen felt that she was in a room in which two people hated themselves yet were interlocked and paralyzed.

Let us underscore a key message from the paper, which follows from Davies's description: that therapeutic impasse entails more than the unwitting identification of the analyst with an abusive figure. A key aspect of this is the self-hatred that an analyst is forced to encounter through a traumatized patient's need to forge a link with the analyst via the patient's persecutory introject (what we have called the alien self). Thus, impasse is more than repetition of a past relationship. It is the current experience of a disorganized self: a pervasive state for our borderline patients, and (it is hoped) a temporary but no less disorganized state in the analyst. Davies's emphasis on the shame that we feel in relation to what our patients force us to become is an invaluable clinical touchstone.

A corollary of this process is the need to identify the thoughts and feelings that remain active for the patient after the successful externalization of a persecutory inner self. This is what is most beautifully illustrated in the move from Karen's Thursday session to her behavior on Friday. The externalization of the self-hatred, now alive in the object, is a creative moment when the self—normally the victim of torment—can be experienced once again. Anthony Bateman (1998) has described this process sensitively in his paper on the momentary accessibility of borderline patients at the point of shift between thin-skinned and thick-skinned narcissism. On Friday, Karen arrived with a thermos filled with sweetness and love, what was left behind once the self-hatred had been externalized. But what makes our profession challenging is that it is so hard to see what is left behind when we are made to hate our patients by the process of externalization. What allowed a switch to happen in the case under

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caregiving behavior (overreaching) in response to the patient's withdrawal. Furthermore, it would have required Karen to have a capacity to envision without major distortion (to mentalize) Davies's subjective state. Davies's perception was accurate, however, and enormously helpful in understanding Karen's inner state in the countertransference.

The paper by Davies not only is clinically very telling but also offers a useful developmental model. In Karen's history, Davies reconstructs a mother whose love was conditional on the acceptance of a profound distortion of internal reality. But this point perhaps needs some elaboration. What Davies points out is that the destructiveness of a malignant object is not the same as a psychotic parent. It is not the perception of the physical reality as distorted that is so damaging for the child's developing mind. Epidemiologically, we know that a frankly psychotic parent is not a very high-risk factor beyond the genetic, whereas having a borderline parent is (Anthony and Cohler, 1987). The psychotic parent comprehensively distorts reality, whereas the borderline parent distorts subjectivity in far more subtle ways. It is obviously dangerous when a child has to adapt his or her representation of true or constitutional self-states to fit the alternative version perceived by an external figure, because of the dialectic manner in which the psychological self develops. We learn about our states of mind by seeing them in someone else. We find ourselves in our own minds through seeing them in the subjectivity of our objects. But if the child attempting to find itself in the mind of the other is confronted with a disorganized self therein, what is internalized does not correspond to what is true or constitutional. It belongs to the other, yet it is internalized into the self. It becomes a dissociated (alien) part of the self. Of course, if the caregiver's self has the same structure of disorganization that he or she is in the process of creating in the child, what might be passed on is the dissociated self that the parent internalized from his or her own primary object relationship. This is the source of the transgenerational pattern that Davies and others have noted in relation to the experience of trauma.

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But the particular value of this courageous paper is the continuity that Davies's model affords to our own experience of disorganization within our selves. Our patients are not alone in experiencing part of themselves as alien. As the paper clearly notes, we all experience parts of the self that can only be adequately dealt with by externalization—parts that we feel were placed there by figures not in tune with our needs, parts that we need to place elsewhere at moments when the clinical heat is on. Davies delineates the damaging part of the process entailed by therapeutic impasse: the projective-introjective hot potato, or Old Maid, or alien self—a card that the analyst holds (with) in his or her own hand. The struggle that Davies describes in the countertransference is engendered when the transference activates the alien self, and the analyst then faces the same unbearable self-destructive emotional state faced by the patient, a state in which projective identification becomes a matter of life and death.

Elsewhere, we have suggested that the origin of this pattern is an infantile relationship of distorted mirroring (Fonagy et al., 2002). The caregiver is unable to mirror the child's state of mind in a marked way. This means that for a child to be able to build an awareness of his or her own states of mind is to be true to his or her experience, the parent must both reflect the states in the child's mind (congruency), in response to their expression (contingency), and also mark them as belonging to the child rather than to herself (Gergely and Watson, 1996). All of our selves contain an Old Maid, an introjective hot potato. None of our caregivers were invariably attuned to our mental states. The complex dynamic, then, is that the therapist, under the same compulsion to externalize as the patient, can sometimes force the patient back into the state that was experienced before the patient's projective process began. The paradigmatic example is the aggressive interpretation of the patient's aggressive attack. Davies is correct in pointing out that a key to overcoming the impasse must be the analyst's acceptance of his or her own badness, or self-hatred. More in action, prosody, and vocal gestures, Davies communicated her awareness of her own evil to Karen. A playfulness imbued this process, indicating the move out of a psychic equivalence mode of functioning. Karen was shown that the content of the mind can be played with, even if shameful, and there was a replication of the parenting function in the integration of the psychic equivalent mode with another mode where nothing is serious. The two together told this patient that her experience of her subjectivity was not a fixed reality.

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How was this achieved? In this instance, there was self-disclosure. Even if the patient knew of her analyst's sense of shame about hating her patient, there was disclosure in the confirmation of this and also of the analyst's self-acceptance despite the recognition of fault. Was this self-disclosure necessary? In this instance, it was. The patient probably perceived it as the return of a real person, as opposed to the unreal analyst at the beginning of the Thursday session, who falsely claimed that she wished to see a patient that she was actually dreading to see. In general, however, we do not feel that seeing the real (self-disclosing) analyst is what makes the relationship with the analyst feel real to the patient. The reality of the interactions (critical for psychic change) comes from the connection—created for the patient by the analyst's mind—between the constitutional self and its second-order representation (what we have called "mentalized affectivity"). The reality comes through the analytic third (Ogden, 1994); in the present case, the separate

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mind that had Karen's mind in mind.

The obvious risk of self-disclosure is implicitly pointed out by Davies, of unconsciously forcing the unbearable parts of the analyst's mind into the patient's mind. When this occurs, an inevitable consequence is that the patient is deprived of a therapist temporarily, turning the patient into a mind that is forced to have the therapist's mind in mind. The essence of overcoming the therapeutic impasse has to be the recognition by the therapist of the real feeling of unease that the therapist's action has created. If the therapist had been able to address the patient's anxiety about being in a room with someone who (as the patient unconsciously sensed) wished to be in bed rather than in the consulting room with the patient, perhaps the impasse would not have occurred. If the analyst had been able to mentalize her own guilt sufficiently to preempt an unwarranted reassurance about her commitment, perhaps the patient's sense of abandonment would also be preempted, and the need for projective identification would never have occurred. Perhaps if the patient's undermining rebuttal, the accusation that the analyst was totally uncaring, had been met by an understanding of the frustration and self-loathing that the patient faced (from being in the room with someone on whom she relied so deeply but whose commitment was experienced at that moment as false and failing), the resentful withdrawal would not have followed.

But these take a call for a rare therapist who does not work when sick, or whose capacity for mentalization is indestructible. And even if Davies were such an analyst, it is conceivable that, as she points out,

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her empathy might have "ricocheted" and been experienced as intolerable by a patient filled with envy at many of these stages. Davies had to become the uncaring therapist that her patient needed her to be. Davies could then overcome what was forced on her and make explicit the states that she and her patient were forced by their respective vulnerabilities to experience. It is therapeutic for us to become a bit like what our patients need us to be so that, through the interpretive action of relationship repair, we may demonstrate the reversibility of mental states, and in a sense enact the overcoming of psychic equivalence. This is perhaps simply a restatement of the classical Kleinian idea of a depressive position, a mode of functioning that admits the integration of the good and the not so good, that permits us to step beyond the primitive gestures of paranoid schizoid states, and—as Davies points out—to see the world of minds as accessible to transformations. The key point made by Davies is that the nature of the analyst's psychotic functioning makes it inevitable that this will happen again and again. In this, she takes a truly Freudian stance, stressing that the analyst's mind is no more or less human that that of the patient, and that, ironically, the very act of pathologizing the patient may be evidence of this.

The issue of impasse, as Davies emphasizes, is not so much how we get into it as how we can get out of it, given that its hallmark is a petrification, a paralysis of mentalizing, that denies access to the only escape route. The key that she demonstrates so beautifully is what Neville Symington (1983) called the analyst's "act of freedom": to do something that is not expected, that forces the patient to think about his or her own thoughts in the context of the analyst's thinking, This is what Davies did with such obvious effectiveness at the end of Karen's Thursday session. Such acts of freedom require courage. Because those who undertake such acts aspire to do something unexpected, they therefore frequently skirt the boundaries of the therapeutic. They also invite unpredictable results, and predictable—sometimes sanctimonious—criticism from colleagues. To preempt such attacks perhaps it is helpful to have "the mother of all colds!"

**References**


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The author suggests some ways in which this important paper contributes to the relational perspective on clinical work. In particular, the analyst's role in owning participation in the struggle for the position of the doer, the "bad one" is seen as crucial to shifting out of the negative symmetry in which each person feels done-to by the other. Davies's crucial identification of the dynamic whereby the child must own all of the badness for the parent helps to clarify how repetition works in the analytic dyad. Whereas the repetition may be understood in terms of the complementary relation of doer and done-to, the owning of responsibility for participation is associated with the space of thirness, the alternative. This author sees the Davies paper as a seminal contribution to the effort to unpack the mystification that projective processes foster, that are concretized in relationship rather than merely in the individual psyche by forcing the other to bear the toxic identity while denying it in the self. Davies's work illustrates how the intersubjective third can be reestablished by the analyst's careful ownership of hatred and also makes clear that the issue is recognition of what cannot really be hidden, except by reproducing mystification in the analytic process. This author also notes that Davies has provided an important redefinition of what has often been misunderstood as disclosure.

Davies's paper, which I believe represents a very important step in relational thinking, has had a powerful effect on my own clinical work since I read it. It beautifully analyzes the dynamics of the identification with badness that permeates many enactments. At the same time, Davies highlights a significant direction for the development of an intersubjective perspective.

The title of the paper brings into focus a deep but elusive aspect of enactments characterized by animosity, namely the way the partners begin to mirror each other, often unconsciously. The enactment Davies describes is characterized by what I like to conceptualize as a kind of breakdown into complementary opposition, the doer-done-to relation (a term Davies has also used; see Davies and Frawley, 1994). But, this clinical encounter shows an aspect that seems increasingly important to me—that each person has a sense of doing to the other as well as being done-to, because each person feels persecuted by the other person's accusations. Thus, a deep structure of symmetry; or negative mirroring, takes hold between the two partners, even though they feel themselves to be in opposition—as when Davies and Karen glare at each other. Of course, Davies not only exposes this dynamic, but also demonstrates (in a way I find very convincing) how the analyst can use her own subjectivity to move out of this symmetry.

Thus, the paper is also an important contribution to our increasingly powerful and transformational realization that the analyst's acknowledgment of his or her inevitable participation can be turned to the good by consciously embracing, learning from, and expressing understanding of that subjective participation to the patient. Davies's work illustrates that 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. Davies highlights the knot of blame and unravels, in a new and exciting way, why each person holds onto his or her own reality, why the space of multiple truths slams shut, and how that door can be reopened. In my thinking, this opening of the door, this owning up refers us to the space of thirness, the alternative to the complementary relation of twoness, of the doer-done-to relationship. The shift is toward a dynamic in which two partners begin to build a third based on mutual recognition, to cocreate a pattern of responses aligned according to the principle of trying to accept and understand the other. As I have said elsewhere (Benjamin, 2004), I distinguish sharply this shared creation of space for feeling, this notion of an intersubjective third, from a one-person model of the third as an observational function or relation to thinking in the analyst's mind (see Britton, 1998). The creation of this intersubjective third is only made possible by substituting the principle of responsibility for the attachment to blame.
I hope I am not presuming too much in generalizing that the background for the kind of enactment Davies describes is precisely that the patient has been subjected to a world where no one is responsible—no one bears his or her own burden of guilt—so there is no way to extricate oneself from wrongness. And since there is no way to have a shared reality except by submission to the other’s “truth,” the only way to retain individuality is to resist any shared reality.

As an aside, in light of recent events in the world, thinking about this problem led me to speculations about how accepting responsibility collapses into blame, so that a fundamentalist insistence on being right becomes preferable to losing one's sense of having one's own perception or identity. Davies's narrative develops the relational proposition that sanity cannot be built on what Hoffman sees as a kind of essentialism, the notion that there is only one truth.

The insistence on the existence of only one truth usually accompanies struggles centering on the question, “Who is to blame here?” This pattern helps to fix both partners in a complementary dynamic that is both coercive and crazy making. One person must be terribly wrong, destructive, or out of touch with reality. Thus, the opposition that takes the form of this kind of complementary twoness requires eradication of difference or a fight to the death. Only some form of thridness can release us or shift this struggle onto an axis where each person can have his or her own reality and recognize that of the other.

Davies shows how she reopened that space of thirdness through analytic surrender (see Benjimin, 2004), overcoming the complementary pressures to retaliate or submit, to choose my reality or yours, to destroy or be destroyed—moving into a space of compassion and acceptance of shame, badness, and pain. The enactment begins with Karen's making a demand, not a request. In an earlier paper, Davies (2003) has given a beautiful description of how she met such a demand with recognition of the underlying longing to feel cared for, loved. She showed how the patient's demand pulls for an extorted response that keeps the dyad locked in the complementarity. In the present paper, she goes further, explicating how the virulence of such interactions lies in the cuckoo clock mechanism: I can only get out of blame if you go in. She exposes how the attempt to avoid being the bad one drives the dynamic and how this dynamic reproduces a parent-child relationship in which something toxic is forced inside the other (the child) while being denied in the self (the parent).

I hear a resonance here with a paper by R. D. Laing (1965) that captivated me as a graduate student in the 1970s. At the time, I was disappointed not to find further development of the idea of mystification in psychoanalysis, and it has been exciting to rediscover that idea resurfacing in recent relational literature (for instance, in Russell, Ringstrom, B. Pizer). In reading the Davies paper, I felt the other shoe drop with a satisfying thunk. She gets to something very deep about how the analyst's locking into the position of feeling shame and blame reproduces the thinking–parent-child relationship. Laing said that the parental system makes the child bad or mad for perceiving accurately the meaning of what the parent really is saying. What the parent communicates is, “You are under obligation to experience, in effect, things as I do and to confirm my reality, but I have the right to disconfirm your reality.” The other's existence as subject with a separate center of orientation thus becomes forbidden or bad.

The important thing is that projection is only one part of the description here. Another aspect is the direct attack on the child's mental function. The transpersonal defense—denying the child the right to speak or protest by labeling that bad or mad—further binds and mystifies. Once this mystifying double bind is repeated in the therapeutic relationship, even the most minute comment about the other person's state (by therapist or patient) would be seen as bad, mad, destructive, or an attempt to make the other person be so. Both become wary of the attempt to shove everything back into them, to deny all culpability, to reject all reflection on their respective sides. This leads to a collapse of thridness that can make thinking and talking about what is happening simply impossible.

Laing (1960) gave a fascinating illustration of how this impossibility of communicating (or metacommunicating) what is going on —with the attendant confusion about whose feeling this is—makes enactment necessary. It is up to the therapist, Laing makes clear, to either hear or remain deaf to what is being communicated about the situation. He cites Kraepelin's presenting in the lecture hall the case of a patient who gives not a “single piece of useful information ... no relation whatever to the general situation.” In fact, the patient mimics the doctor and replies quite clearly,

What is your name? What does he shut? He shuts his eyes. What does he hear? He does not understand; he understands not.... When I tell him to look he does not look properly. You there,
just look? ... Attend; he attends not... Are you getting impudent again? ... You don't whore for me.... You understand
nothing at all, nothing at all; nothing at all does he understand [pp. 29-30].

If we note the shifts from you to he, we see how the ambiguous speech—the difficulty of saying who owns the behavior, the
feelings, the accusation, the criticisms—gives expression to the hall-of-mirrors positioning of self and other that drives the enactment.
While mimicking the psychiatrist by saying, “He understands nothing,” the patient informs us who really doesn't understand. In the
effort to dramatize how he senses that the psychiatrist sees him, his commentary becomes indistinguishable from expression of his own
feeling—self and other, self-expression, and observation collapse.

Thus, in such enactments, both analyst and patient can be caught in a life-and-death battle for sanity and mental integrity,
threatened with loss of reality. The accompanying feeling may be a horrible sense of wrongness, being wrong, being in the wrong. The
struggle to be right, to define what is going on, to insist on the other's blame and wrongness then seems like the only way to get this
wrongness out of the self or the self out of wrong. Davies proposes that because the analyst has probably struggled for sanity in her
own life by perceiving the pathology of her love objects, she now relives being caught between locating the problem in the other and
needing/wishing to cure that person. She cannot, seemingly, cure without taking the shame of being not sane—yet how can she cure if
she isn't sane? Then again, if she chooses to see herself as sane, she is guilty of driving the patient crazy. The very fact that she is
guilty of doing this makes her feel more done-to, persecuted; guilt and shame mesh. As Davies vividly describes by replaying her
thoughts during Karen's session, the child/analyst cannot find a relation to a true third in her mind, one that helps her to observe and
calm down (down-regulate her own arousal). Instead, the analyst becomes subject to a persecutory third that points the finger at her for
being a bad analyst.

So I add to Davies's formulation that the child's/analyst's predicament is risking the loss of love and the sense of goodness because
if she maintains her own reality she can be guilty of destroying the parent/patient's mind. If the analyst does not take on the toxic
projection and agree that she has done something terrible to the patient, the patient can disintegrate, losing her mind right there. Thus,
not only

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love and goodness are on the line; it also feels as though somebody's psychic survival or sanity is at stake. The analyst could be guilty
of soul murder. I may question Davies's assertion that such enactments do not imply the existence of a more malevolent or virulent
introject in the patient's history. She seems to imply that such an enactment is simply the way the particular analyst and patient lock in
to each other's extruded badness. Although different analysts would surely have different ways of locking in, with different results, it
still seems worth considering that one (if not the) crucial index of malevolence is the degree of force used to bind the child to the
parental projection. The forcefulness of projection correlates with the process of active mystification, which undermines the capacity to
place any trust in one's own mind.

One mystifying aspect of the hot potato game Davies analyzes is, as I said before, the underlying symmetry: to be a doer is to be
done-to; to claim being victimized is to attack the other; to be accused is to feel powerless. Who is now the doer, the done-to? The
parent who is reproaching the child for badness is communicating, “I am you and you are me.” I found especially illuminating Davies's
analysis of the parental communication: “It is BAD for you to be that which I deny I am” and “You must be it.” Because the child
internalizes these two contradictory injunctions, it is impossible for her as patient to play the parts separately. One result of this bind is
that the analyst may find it impossible to talk about it (Ringstrom, 1998). If I, as analyst, respond to your (the patient's) criticism by
showing that you (the patient) are doing something to me, then I am involuntarily mirroring you (the patient) who insists that I am bad
and that I am doing something to you. Therefore, the more each I insists it's you doing it, the more each I becomes you, and the more
blurred our boundaries are. The more my effort to save my sanity mirrors your effort to save your sanity the less sane either of us can
be. The insidious oneness of tiveness is that there is no outside other; no one survives.

One way of looking at the deep structure of repetition is to see it in terms of the absence of the reality of the outside Other. The
Other mirrors your fantasy. The subject faces this dilemma: whatever he or she gets him or her in deeper unless the Other makes a
change. The analyst struggles with how to be that Other, how to transcend the loss of reality and the shame that paralyzes me, how to
become the Other who surrenders, cops the plea, and bears the guilt without submitting.

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I'd like to think that I'm going to remember all that because the beauty of Davies's initial remark to Karen lies in its simplicity.
Karen said, "You hate me." This means, in effect, "You are bad because you want to deny your hate and say that I am the bad and
hateful one.” Davies's reply was, “Sometimes we hate each other, I think.... I guess we’re gonna have to see where we can get to from here. Neither of us likes it much, it just is.”

Davies is particularly adept at understanding the use of disclosure, in my view. It was wise for her to wait until the following session to say her next thought, which was that in this situation, she starts hating herself. Had she said it in the first session, it might have experienced as her saying, “You are making me be the self-hating one.” More important, bringing in this experience of her own reintroduces separation of herself and the patient, whereas initially, the point seemed to be “We both feel bad.” The question, “Am I crazy or are you?” has to be answered, “Both.” The most profound truth is the one Davies expressed, as if to say, “The feeling is mutual, we cannot extricate ourselves, in this dynamic we are stuck together. (Like rubber and glue, everything I say bounces off you and sticks to me and vice versa.)”

What I see as powerful here is that the complementary twoness is dissolved by acknowledging the We—an analytic third (I am using it in Ogden’s 1994 sense), a shared entity that now contains us (and our dissociated parts). There is no separate self into which to evacuate, no Other plate to pass the hot potato onto, only Our plate. What is being acknowledged is the most primal form of threeness (in my sense; see Benjamin, 2004), the one that consists of our having the same feeling. It is based on primary experiences of accommodation, affect attunement, and rhythmicity such as that which infancy researchers have illustrated (Benjamin, 2002). It is the basis for letting go of ego attachment to being right or different or better. In this situation, Davies illustrates how she and Karen achieved that recognition of sharing the same state even in relation to negative affect.

At other junctures, we may achieve surrender by finding our way back to empathic identification with the patient's hurt and sorrow, by recognizing loss. But in cases like this, as Davies says, badness and goodness must be held jointly to get out of the tug-of-war of mutual evacuation. The analyst’s efforts to be understanding, to be good, to be empathic could drive the patient back into the shameful position

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of being the bad one. Recognition of shared badness is a better route into the threeness of mutual understanding, which would be blocked to the extent that it is seen by the patient as an attempt to weasel out of badness and blame her.

Davies's move did convey recognition of loss: “We can’t be Good, I cannot love you right now.” Instead of goodness, however, we can have a moment of truth, an acceptance of What Is, our feet can touch the solid ground of reality. This surrender to what is, not getting hung up in aversion to the bad, makes movement possible—out of oppositional twoness. Davies was conveying: “Perhaps if right now we can be bad together at the same time, then we can also both be good.”

So the logic of her intervention is good, and the moment of meeting around milk follows. As the twoness dissolves in milky oneness, and Davies is having worrisome thoughts about all the transferenceal meanings that could come back to haunt her, she decided to stay in the moment, allowing a reversal of complementarity in which Karen was the giver and Davies was the receiver. Karen was able to experience herself as the healer, the one with something good to give—a very strengthening and underacknowledged part of analytic work in which the patient discovers her own generosity and loving capacities. This was another moment of what I call the primal or energetic third (Benjamin, 2002), when together patient and analyst create a harmonious dance of sips and glances, oneness.

But this primal third of accommodation became a true symbolic third when the harmony could expand, could withstand dissonance, as Davies—like the mother who must administer bad-tasting medicine—kept her eye on the necessity of holding bad and good in mind together. She said, “What of those two awful people?” But lest this dissonance become too overwhelming, she was saying, in effect, “Let me carry this potato for a while; let me be the one who models what it means to take responsibility.” She said, “I hated myself,” meaning “Let me bring in both sides of my subjectivity, good and bad, and show how they can be the two hands that hold what must be spoken.”

Because Karen saw that Davies was not reintroducing the sour note to reinstitute the back-and-forth of mutual evacuation or to silence Karen’s perception of hate (“You hate that me”) with denial, she too could own the hot potato. The shuttling back and forth of blame came to a halt. Then, speaking of how it felt to share vulnerability as well as

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to be coconspirators in owning a toxic self, Davies and Karen could enter the space of moral threeness. (The moral third, as I define it, is based on a principle of witnessing compassion rather than moralistic/judgment. It is the compass for analytic practice.)

Davies makes an important point in saying that calling her statements self-disclosure would constitute a category error. It is disclosure only to say, “I am feeling hate now.” The intersubjective truth (that everybody has a hot potato, and everybody hates) may
be obscured when we are in the grip of the complementary win/lose game of “Who is the bad guy?” But in the bigger game of life, hate is not news, and it shouldn't be. It is news, however (the news of difference) to patients, that someone can admit to such a feeling rather than try to evacuate it into them. And unfortunately, our analytic world has often made it news to analysts—a fact that for a long time virtually doomed us to play hot potato with our patients. Our collective vision put so much emphasis on the idea that patients repress, deny, project, or otherwise disown their aggression that we lost sight of the fact that patients also often know that they are full of hate and are relieved to find the safety to talk about it. The news for analysts and patients may be that patients can speak about it without sacrificing for or submitting to the other. The news for everybody, in varying degrees, is what constitutes the experience of moral thirdness—a direct hit of truth, freedom, and nonjudgmental compassion—an experience such as the one that Davies and Karen cocreated, which shows how mutual identification can serve to contain rather than suppress breakdown, disruption, aggression.

The key relational move elaborated here is that making the analyst's experience a matter of explicit discussion breaks up the mystifying dynamic of denial that drives the complementary game of hot potato and maintains the underlying mystification of the hall of mirrors. Mutual evacuation gives way to mutual recognition. I also believe that Davies's paper may help us think about the move from “It's either you or me,” to “It's both of us,” in terms of a shift from dissociation to association. The dissociative process begins as we separate ourselves, through thinking, from the affective connection to the other person in order to separate from the painful feeling evoked by that person. Isn't awareness of our own dissociation part of what triggers our shame and guilt? Feeling caught holding the bad card, the analyst may sometimes be the one to start the game of counterprojections.

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When the analyst's sense of shame and failure is triggered, his or her observing faculty loses its base in the moral third. Analytic ideals simply become a punitive form of scrutiny, a shaming judgment that collapses the space of thirdness inside self and between self and other. Much of the shame that an analyst feels results from his or her relationship with the fantasy of the judgmental other, an internal third representing the negative observation of the analytic community. It may subject the analyst to withering contempt for ineptitude or terrible guilt for having caused the patient suffering. This internal negative third does not actually open the space of observation, and in that sense is not a true third. It does work as a substitute for a true third in many cases (Benjamin, 2004). This is particularly noticeable in supervision, when the therapist assumes the enactment to be the result of his or her mistake rather than an example of the larger principle of repetition, whose flip side is repair. In such cases it is the supervisor's role to remind the analyst that failure, and repair of failure, is necessary to the process (Bromberg, 2000).

Freud knew about what he called action, and also about repetition. He said that no one could be slain in effigy or absenta. But unfortunately, he never came to grips with the intersubjective manifestations of repetition. He proposed that the analyst can stay clean, can be like the chemist handling dangerous chemicals. This denial that we too are chemicals only contributed to the combustion, misleading us about repetition and confusing us about the meaning of commitment to the third, conflating the third with impossible ideals.

I used to wonder, when I first began this work and struggled to stand under the weight of my own self-judgment, how (in the moments of challenge so well evoked in this case) other analysts lived up to those ideals: correct interpretation (which I can't seem to find right now), neutrality (which I can't embody in this moment), the well-analyzed analyst (who doesn't feel shame as I do) who knows what is going on here (which I don't!). Eventually, with the help of my colleagues, I came to see the futility of such judgment and instead began to hope that we could change our analytic norms from “ought” to “is.” I came to think our moral third needed to expand to include the ideas of reality, which means accepting the dialectic of repetition and repair; of honesty, which is always tempered by awareness of our unconsciousness; of freedom, which would be our desire; and of compassion, which we sometimes attain. I imagined that our community as a whole could take some of the heat, help carry the potato, and widen that space of moral thirdness that acknowledges our human fragility in a way that helps us to be honest and responsible at the same time. I can see no better way to end than as Davies did, with Karen's dream, imagining ourselves extending a hand to each other, creatures who bear guilt and shame as the mark of our human destiny. It is a privilege to engage with Davies about her inspiring and pathbreaking work.

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The following response to discussions by Benjamin and by Fonagy and Target focuses on several issues raised, including linearity versus multiplicity in the assessment of developmental capacities, the complex interplay of shame and subjectivity in an intersubjective field, the notion of surrender in resolving therapeutic impasse, and some thoughts on the concept of the third, as they are exemplified in this case material.

This paper has been something of a personal journey for me. I expected to present it at the first biennial meeting of the International Association for Relational Psychoanalysis and Psychotherapy, on a panel I would share with Stephen Mitchell, Irwin Hoffman, and Jessica Benjamin. As it turned out, I wrote the paper in the months following Steve's death and presented it at the conference, which was then held in his honor. It was my hope during those months of writing to fashion a paper that would embody Steve's spirit: his deep commitment to clinical psychoanalysis, his fascination with the relationship between theory and technique, and the sincere integrity he brought to struggling through the often maddening relationship between the two. In my own mind, the paper became a personal tribute to the man who had been my teacher, mentor, and close personal friend. And though it is for the reader to determine the ultimate success or failure of my tribute, I want to thank Jessica Benjamin, Peter Fonagy, and Mary Target for contributing to this project. Although I cannot agree with everything they have to say, I do feel deeply recognized by each of them in the way that they have engaged with my clinical work and with my theoretical speculations. I feel their respect but also their disagreements, their appreciation but also their challenge to sharpen my own thinking and respond to the points they raise. I am moved by the seriousness with which they have undertaken this task, because in my mind's eye, I can see Steve smiling at the quality of scholarship their discussions have brought to the journal he founded and loved.

I begin with the discussion by Fonagy and Target because the clinical perspective it fosters involves some underlying theoretical differences that it will be helpful to articulate at the outset. I then turn to Benjamin, with whom I share a clear theoretical and clinical resonance.

Fonagy and Target propose that therapeutic impasse occurs at the moment of empathic failure, what they consider a "mentalization mismatch," and they point to the moment at which the little-girl part of Karen—the hungry, needy abandoned daughter sat before the sick and tired analyst, who seemed to her, in that instant, not unlike her depressed and unavailable mother. They believe that a more empathic recognition of Karen's despair in that moment, a comment that focused on her deep disappointment that her mother was again unavailable, would have at the very least postponed the therapeutic stalemate by obviating the need for a projective identification through which Karen aimed to reestablish her connection with me. They go on to see my "I so wish that I had a time" statement to Karen as a secondary empathic failure, a defensively disingenuous remark that left the patient feeling misunderstood and abandoned, her anxiety unrecognized and therefore unmentalized. From their perspective, Karen was functioning in the psychic equivalence mode and therefore was incapable of holding multiple perspectives. Her disappointment in the moment could not be offset by any comment of mine that attempted to resuscitate an alternative transference-countertransference state. She had been disappointed, and I was therefore inadequate and rejecting. That was the only reality she knew. My comments therefore negated her experience and was from the perspective offered, an even deeper emotional abandonment.

I find this description of my therapeutic process to be compelling but somewhat different from my own understanding in a way that I think underscores certain important clinically significant theoretical differences. I do not see Karen as "one self" who is developmentally and cognitively unable to mentalize and play with multiple realities. I therefore do not understand the impasse as growing out of a failure (understandable or not, inevitable or not) to help Karen mentalize her experience of me as a rejecting, disappointing, sick, and inadequate
transference stand-in for her psychotically depressed mother. Although I have studied Target’s and Fonagy’s developmental model and find it enormously helpful in my clinical practice it focuses more than I would on a linear model of mind and its developmental deficits. The therapeutic action focuses on reopening the developmental process by helping the patient to mentalize rather than evacuate disowned aspects of the self. I see Fonagy and Target’s version of the clinical moment as one highly significant aspect of the clinical impasse. For example, I agree with them that my comments to Karen on that Thursday afternoon were not terribly helpful, that they did not help her to mentalize her rage or her disappointment. In fact I agree with their whole description of the process between us, as far as their description goes. But from my perspective, Karen not only experienced herself as the victim of my illness and empathic limitations, but she also experienced herself as the abuser who had made me sick and worn me out. She not only felt abandoned by my illness and unavailability, but was also tormented by the fear that her hatefulness and relentless rage had caused it. There is the part of Karen who feels loved by her mother if she takes blame on herself, badness into herself, and submits to her mother’s version of reality. And there is the part of Karen who clings to her own perceptions of the world but believes her determination to remain separate from her mother is ultimately responsible for driving her mother crazy. She holds onto her sanity only at the expense of feeling unloved. Therein lies the choice between sanity and love that I attempted to describe. The therapeutic moment held all of these potential relational transference-countertransference enactments. I also believe in a part of Karen who is older, healthier, more resilient, and less fragmented by warring and conflict-ridden self-other organizations. I believe in what I have called an emergent self-state, one who begins to identify with the analyst and with a self in relation to the analyst and others in her life who have offered something more empathic, more resilient, and more alive—a self-state that has more access to the totality of the patient’s experience of herself and others, an integrative self who is able to move more fluidly across identifications and counteridentifications to experience a wider breadth of her own internal potential simultaneously.

Therefore, my own perspective on the enactment focuses less restrictively on the developmental deficit in mentalization (although I agree that it is there) and places more emphasis on the relational

conflict in self-other identificatory configurations that forced the unmentalizing Karen into the foreground of the transference-countertransference arena at the particular moment under discussion. I see this, in essence, as a moment of regression for Karen, but regression from a relational perspective—a regression in which a more primitively functioning self-other organization emerges into the foreground of the work and fills the transference-countertransference enactment with its own developmentally driven purposes. Because I see each self-other organization as carrying the cognitive-affective imprimatur of the developmental epoch in which it is organized and set down, I agree with the formulation that “Thursdays Karen” is functioning at the psychic equivalence mode and therefore saw me only as sick, disappointing, and abandoning. I also believe, however, that a host of “other Karens” were at least potentially available, seated around the sidelines of the enactment and watching it unfold. For some reason that was conflictually driven and still unformulated and unconscious at the therapeutic moment described, it was the unmentalizing Karen who had been “appointed” to meet with me. Was it my illness that drew the younger, more vulnerable self-state? Might my neediness in that weakened state have evoked Karen’s early conflict between sanity and love?

There are endless possibilities; my point is to speak to the importance of searching for the transference-countertransference significance of any therapeutic dissociation (see Davies, 1996, 1997) in which only one regressive self-state fills the therapeutic arena. In this context, I believe that it is important to consider that any one comment made to a patient will be heard at multiple levels of cognitive development and meaning-making ability. My comment to Karen, that “I so wish that I had a time” fell on the deaf ears of the unmentalizing Karen but could potentially be heard by other aspects of self for whom it would have a significance in terms of my intention and my willingness to try to meet her needs when possible. I might consider these self-states to be the “grieving” Karen, the “depressive position Karen,” the one who knows that even when they have the best intentions, her good objects will fail her. It was my therapeutic hope that my comment would be heard by these other self-organizations and that those parts of Karen would help me to hold and contain the unmentalizing Karen who sat before me in an icy and unrelenting rage.

An analyst’s comment thus has the potential to mobilize the patient’s own self-regulatory capacities and to make the therapeutic work with
the younger self-state a partially collaborative endeavor. The therapeutic challenge is to pitch our comments to patients in such a way that both the more regressed and the more competent and resilient self-organizations become engaged. It is no easy task, and I am in complete agreement with Fonagy and Target that much of my paper speaks to "the sheer impossibility of apprehending, let alone appropriately responding to, the complexity of unconscious communication between patient and analyst in a single session." I would only add "in a single moment." To my way of thinking, the task of therapeutic "neutrality" is to make sure we are addressing a host of different self-other configurations and to avoid the trap of being pressured by a particular countertransferenceally motivated need to address only one state again and again and again. It is in the interpretive crisscrossing of concordant and complementary identifications that interpretive comments can create a woven tapestry of containment across otherwise dissociated organizations of self. The multiple, perspectival position so absent in a state of psychic equivalence, can then be fostered and developed.

Finally, I would like to address the issue of self-disclosure as it occurs in this case. I have long felt that the term self-disclosure has outlived its usefulness. In working intersubjectively and coming to appreciate the therapeutic potential of the analytic relationship, the issue is not so much whether or not a particular self-disclosure occurs, but rather the role of the analyst's subjectivity, implicit and explicit, in fostering the patient's self-awareness, self-reflection, and therapeutic progress. Fonagy and Target clearly believe that, when the countertransference has been adequately dealt with, the analysts subjectivity should be held implicitly in the background of the work, informing interventions and communicating to the patient wherever possible that the analyst holds her in mind. The countertransference is metabolized and used by the analyst to deepen her understanding of the patient's experience, and to communicate the depth and quality of that understanding through the interpretive comments offered. Again, I have no objection to this essentially Bionian perspective, which sees it as the analyst's task to hold the countertransference and transform it in such a way that it can be given back to the patient in detoxified form. On most occasions, this is a reliable and well-tested aspect of psychoanalytic process.

The question I would like to raise, however, is whether it is ever therapeutically important for a particular patient, especially one with

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a psychotically inconsistent parent, to not only find her own mind within the mind of the therapist, but to also encounter the separate mind of the therapist and actively disentangle it from her own mind and those of her significant transference objects who are lodged there via projective identifications. Patients often find themselves in the minds of their analysts via comments and interpretations that are exquisitely attuned and empathic. However, given the inevitability of empathic failures and shortfalls ("These ifs call for a therapist who does not exist, one whose capacity for mentalization is indestructible"), it behooves us to think about how we want to intervene when the patient in fact encounters in the analyst an evacuated part of her own internalized object world, or a disavowed part of the analyst's own internal object world that is unavailable for self-reflection and psychic processing.

I believe that in certain of these situations it is most important for the patient to understand what it is that the analyst feels in interaction with her: not details of the analyst's private life or feelings that will derail the patient's own psychic journey in the analytic process, but reactions held by the analyst due to the projection of either concordant or complementary identifications—projections that, when identified with and then acknowledged, may shed light on disowned aspects of the patients experience. Fonagy and Target state,

The reality of the interactions critical for psychic change comes from the connection—created for the patient by the analyst's mind—between the constitutional self and its second-order representation (what we have called "mentalized affectivity"). The reality comes through the analytic third (Ogden, 1994), in the present case, the separate mind that had Karen's mind in mind.

I entirely agree with these statements. I believe, however, that our processes of achieving this end differ in subtle ways that it is helpful to delineate. The intense shame stimulated in patients like Karen, in response to the very affects that require mentalization and self-regulation, is the psychic condition that reinforces their continued evacuation and projection. Our clinical dilemma is how to help patients keep this shameful experience within tolerable limits, therefore facilitating the mentalizing, regulating activity we deem necessary. So

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what we have all labeled a self-disclosure has (in this context and to my own way of thinking) two very significant functions. First, as stated in my paper, my experience indicates that making the kind of deeply empathic statement that Fonagy and Target favor, at a moment when the patient is overwhelmed with a shameful experience of her own murderous rage and envy, has the potential to
exacerbate that shame and reinforce the projective evacuation of the patient's own experience. In essence, it is like saying to the patient, "My goodness is so deep that it can survive anything and everything you throw at me." Here, rather than feeling deeply understood the patient can feel even more deeply ashamed that the analyst's "good breast" continues to function while her own has turned deeply sour. Letting the patient know that the analyst, too, struggles with deeply destructive affects may become essential in reducing her shame and thus helping her to tolerate these experiences within herself.

The second purpose for such a "self-disclosure" is to allow the patient to witness the analyst's capacity to tolerate, survive, and even play with affective states she has unconsiously deemed intolerable. In this sense, the patient can begin to "play" with dangerous affect states which she has been too frightened to touch. She can speak of them, fantasize about them, and make sense of them, hold them, and live with them inside herself. But the significant difference may be that the affect states she has avoided now become tolerable because they exist inside the analyst as well as the self. They are shared by patient and analyst and contained within them as a collaborative experience. Rather than one "good" person and one "bad" person we have two human beings struggling together to modulate what each has the potential to feel.

I believe that it may become essential for the patient to meet not only the "separate mind that [has] her mind in mind" but also the separate mind of the analyst as it struggles with her own unique experience. The patient may need to understand what the analyst feels; when in the interaction with the patient the analyst began to feel that way; and how the analyst intends to deal with the feelings, make sense of them, hold them, and live with them inside herself. In this way, the patient may come to understand that the analyst exists outside her expectations and projections. She learns that the analyst has survived the negation of her projections, and her own murderousness may begin to modulate and soften. The reduction of

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the patient's shame, in concert with an analytic response that emanates from outside the projective sphere, may allow the patient to reintegrate some of those affective experiences previously deemed too toxic to own. The concept of self-disclosure at one time useful in our articulation of a new psychoanalytic paradigm, now seems insufficient to hold its own complexity. We need some new terms and a more fully rendered articulation of the role of the analyst's subjective reactions in both facilitating and foreclosing analytic process.

I now turn to Benjamin's illuminating discussion of my paper. In some sense, this is a more difficult discussion to enter because there is such theoretical compatibility and deep clinical resonance between us that it is hard to say much besides "Yes, absolutely," "Yes, you understand what I am getting at precisely," and "Thank you." But to simply express agreement and thanks would not sufficiently recognize the effort, intellect, and clinical sensitivity expressed in this commentary. And so I will respond to Benjamin, not by articulating difference, but in the way that she responded to my paper, via a continuing explication of relational theorizing and clinical process.

In large measure, Benjamin and I have both been splashing around in the same clinical waters. We are both intrigued by the difficulty of dealing with toxic projections without falling into an exacerbated psychotic transference, the danger of perpetuating a split complementarity of "doer and done-to," as well as the problem of leaving the patient's rage, murderousness, and sense of toxicity analytically untouched. Some of our terminology may be different, but I believe the reader will recognize the clear overlaps. In large part, Target and Fonagy approach the same problem. It is their belief, however, that clinical movement can be achieved by one person's (the analyst's) processing and metabolizing the other person's (the patient's) toxic projections and handing them back, interpretively, in transformed ways. Benjamin and I both take the position that two people are necessary for this process to be accomplished, and herein lies the essential relational difference. In what Benjamin calls the creation of an intersubjective third and what I call a therapeutic dissociation (i.e., accepting the countertransference experience that allows one to enter the enactment), there is an acceptance of the inevitability of both empathic rupture and repair as well as a theory that accounts for and clinically emphasizes it. It is not simply inevitable as in Fonagy and Target's model, but rather, the rupture itself (as well

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as the repair) becomes necessary to accomplish therapeutic change. Thus, the old becomes juxtaposed against the new relational potentials. The old becomes disembodied and is seen as only one possibility among many. Although Benjamin, Fonagy, Target, and I all believe that psychopathology reflects a collapse of multiplicity, it is the particular relational perspective that the patient must first fall into the old patterns and then experience something different in the analytic relationship before she can give up the certainty that marks her singular perspective. I hope this case has demonstrated, however, that it is not simply a matter of providing a different experience. The transference-countertransference processes that in large measure control the unconscious co-construction of the analytic engagement mitigate against such difference pulling us again and again back to the old. Therefore these processes must be

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recognized, contained, verbalized, and ultimately symbolized by both participants before something new can happen between them.

In the model that Benjamin and I offer, it is the patient's shame that in large measure propels the dissociation, evacuation, and projection of the unacceptable. There is shame about feeling hateful, shame about choosing love over sanity, shame about seeing the others forbidden vulnerability, shame about feeling separate from the other and thus precipitating her mental collapse, and ultimately shame about the aggression involved in choosing one's own sanity over merger with and love for the psychotic other. I believe that the intolerability of shameful experience and its impact on psychic processes and human relationships remains one of the most important and undertheorized aspects of psychological experience. (Of course, there are exceptions to this statement. See in particular the important work of Morrison, 1989.) Because of the intense psychic pressure to evacuate that which shames us, often the analyst must speak of her own experience first (see also Davies and Frawley, 1994). In this situation, the patient is given an opportunity to identify not only with the healthier aspects of the analyst's ego but also with the way in which the analyst can own, contain, and tolerate her own more pathological structures—structures the patient clearly identifies with her own shameful parts. When the analyst maintains a clearly interpretive position with respect to that which shames the patient (even an empathically interpretive position, or especially an empathically interpretive position), the patient's shame may be increased and not reduced, and the patient's determination to

INDUCE IN THE ANALYST THE HORROR AND SHAME THAT SHE EXPERIENCES IN HERSELF IS REDOUBLED.

In her commentary, Benjamin suggests that in order to resolve the complementarity and work past it, the analyst must “surrender” to the patient and bear the guilt of what has occurred between them “without submitting.” She states, “If the analyst does not take on the toxic projection and agree that she has done something terrible to the patient, the patient can disintegrate, losing her mind right there.” I find this particular formulation a bit unclear and potentially problematic in the clinical realm, and I find the word surrender problematic when used in this way. How does the analyst surrender and bear the guilt for what has happened without creating an experience of sadistic triumph and potentially fragmenting grandiosity for the patient? How does she “take on the toxic projection and agree that she has done something terrible to the patient” without creating an intensified psychotic transference with patients who are particularly vulnerable to such experience? I am not entirely sure what Benjamin is suggesting here, but let me offer some clinical observations and suggestions of my own. I may be explicating precisely what Benjamin has in mind, or I may be disagreeing from a clinical perspective.

For me, one important answer to the dilemma lies in keeping the clinical interaction focused on the affective experiences of patient and analyst, not on the more concrete debate over what has been done to whom. In other words I need not accede to having done something terrible to the patient, an admission that might not fit my reality, in order to own the possibility that my actions have made the patient feel quite awful. Acknowledging that my actions have created pain for the patient allows me to take responsibility for the impact of my actions, and to recognize the patient's emotional reality and empathize with it, without devaluing my own reality. Similarly, I can acknowledge that something about my interaction with the patient has made me feel hate for her in that moment, without suggesting that she has done something terrible to me or, even worse, that she herself is hateful. I can accept that my intent was different from the ultimate impact of my action, and I can accept responsibility for the impact and feel deep regret about it without entirely occupying a toxic projection. Likewise I can accept that the patient's motivations may have multiple levels of intent and meaning. The fact that her actions elicit hatred in me may be only one aspect of their unconscious agenda.

It is not that I hate her; it is that, in this moment, we hate each other. In addition to all that has already been said about this moment, I would add that actions are right or wrong, feelings are capable of eliciting misunderstanding. Feelings may be disruptive and upsetting but they are not “wrong.” Feelings between two people can be worked on. Granted, the actions that caused those feelings can be right or wrong. But I believe that the focus on affective reaction rather than concrete behavior gives both participants in the analytic endeavor far greater latitude for negotiation. We can both be sane. We are both capable of hate and insensitivity.

Of course, this position brings us to the question as to what happens when the analyst does come to feel that something in the countertransference has led her to engage in an action against the patient that was deeply insensitive or even cruel. In this instance, I believe that nothing short of a full admission and apology, along with a full exploration of what led to this state of affairs, will suffice. But this situation for the analyst is quite different, because an admission of her insensitivity or cruelty does not demolish her own sense of reality. In this case, she becomes aware of her behavior and the feelings that elicited her actions. The admission of guilt, difficult though it may be, does not leave her feeling insane.

It is worth noting here that in both scenarios, the experience is subjective. Whether the patient's accusations fit or don't fit one's
own reality as a therapist says little about the “actual” state of affairs. We are speaking not about experiences of right or wrong, but about transference-countertransference moments of affective resonance or dissonance. There are times when we feel that the patient's observations about us are right or wrong, and times when the patient feels that our observations about her are right or wrong. Given that by definition transference-countertransference processes are unconscious, this is an important distinction to keep in mind.

The significant and often difficult clinical choice presented here raises the question of when it is most helpful for the analyst to indeed surrender to the patient's different experience of an interaction, setting aside her own experience of the moment. When should the analyst “occupy” the transference experienced by the patient (including an experience of the analyst's malicious intent and culpability), and when is it clinically more useful for the analyst to accept the patient's experience and explore it while holding onto the analyst's own different

emotional reality? This, I believe, is an open question and an area ripe for much fruitful clinical exploration.

Finally, I end my response with some thoughts about the concept of the third in relational thinking. I believe that too often the term, as used by Benjamin, is misunderstood and used clinically in a way that she does not intend. Too often I have heard the third used to describe a kind of analytic space that exists outside enactment, when transference-countertransference distortions have been worked through. There is a sense in these writings that the third reestablishes a form of objective reality testing, a kind of intersubjective observing ego via which patient and analyst have together emerged from a difficult piece of work and are no longer dwelling in the land of transference-countertransference distortion or potential distortion. One gets the sense rather, that both participants experience a world of momentary interpersonal lucidity in which they feel that they are merely waiting for the next round of enactment to begin. I believe that those who use the term in this way have lost sight of the fact that the third is an intersubjective space. It is not a place in which transference-countertransference issues have been resolved but rather a place in which patient and analyst, for the moment, agree on the nature of what has been transpiring between them. Again, it is moment of interpersonal resonance as opposed to interpersonal dissonance. Patient and analyst view the process between them in a way that facilitates mutual understanding, and they “incline together” in a direction that seeks yet more understanding. It is extremely important from a clinical perspective, however, to remember that this newfound sense of mutual understanding is purely subjective for both participants and may in fact be a new iteration of the same enactment, or the end of the last enactment but the beginning of a new enactment, or both. Thus, the third is not a space or an accomplishment, but (as Benjamin terms it) a dynamic. She describes it as “a dynamic in which two partners begin to build a third based on mutual recognition, to cocreate a pattern of responses aligned according to the principle of trying to accept and understand the other.” Her definition of the term bears more affinity with what we used to call a working alliance than with any notions of objective insight or working through. Even here, though, the third retains a playful subtlety. It charms us, it lures us, it gives us a goal toward which to “align,” but we must remember that it also deceives us. It sustains the complexity and multiplicity of

intersubjectively constructed meanings that the more objectively based term working alliance lacks.

Let me conclude by once again thanking Benjamin, Target, and Fonagy for their very serious readings of my paper. The opportunity to engage with analytic thinking at this level has been exciting and illuminating.

References


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