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

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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 comment 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
transferential 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 countertransferentially 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 analyst’s 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 patients 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
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
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 unconsciously 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, in short attempt trial psychic elaborations of
them which have been foreclosed to her. 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 between 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
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 analysts 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, definitely,” “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
as the repair) becomes necessary to accomplish therapeutic change. Thus, the old becomes juxtaposed against the new relational potentials. The old becomes disembedded 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 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 decimating 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 is it 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 a 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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