

Psychoanalytic Controversies

Discussion

Vic Sedlak

*British Psychoanalytical Society, 27 Moorfield Road, Ilkley LS29 8BL, UK –
sedlak@blueyondar.co.uk*

I would like to begin by making a distinction between intersubjectivity as it is most usually understood in psychoanalytic literature and how it is portrayed in some of the more radical versions of relational analysis. Essentially I want to state a case for a psychoanalysis that is firmly rooted in an understanding that psychoanalytic data, and primarily the relationship between analyst and patient, is intersubjectively created. What I want to argue against, however, are some of the theoretical and clinical implications that some of the relational psychoanalysts have developed and which are illustrated in your paper. I think that the points where we most profoundly disagree are on theoretical and technical issues relating to how clinical transformation, change, is achieved in analysis.

As I understand it, a psychoanalytic approach which is intersubjective acknowledges that the analyst, when he or she is working well, will listen to the patient from within, if I can put it like this, his or her own personality. That is to say they listen by registering their own, undoubtedly idiosyncratic response to impart meaning to what they hear. This is their means, their *only* means, to make a judgement about the emotional quality and meaning of what they listen to. This is an unfortunate fact about our profession, we have no other measuring instrument. There is no avoiding this; in the circumstances, we can only try to make the best of a bad job. We do have the analytical setting including the internal analytic stance to contain us in this job and to enable us to think about the thoughts, feelings, memories or bodily sensations that occur in us. Nevertheless, as psychoanalysts we are also very aware that much of our personal response to our patient will be unconscious and more likely to be enacted rather than contained and understood. Hence we play our part, consciously and unconsciously, in creating the situations we find ourselves in, in any analysis. The thing that is created between our patient and ourselves is an outcome of two personalities meeting and engaging with each other. We do not claim to be objective observers. I think almost all of us, certainly within our British Society subscribe to a view that psychoanalytic facts are intersubjectively created in the broad sense in which I have described this process.

Over the last 25 years there has been a growing international consensus about the clinical usefulness of conceptualizing a co-created relationship which is largely unconscious but hugely influential in any analysis. The Barangers (1961–62; published in English, 2008) in South America termed

it the field and termed a pathological stuck and limiting feature of such a field a 'bastion'; Ogden (1994) in the States has written extensively about an analytic third; much of Ferro's (e.g. 1993) work in Italy is in the same tradition. Here in Britain we have not developed a separate term for this phenomenon; I think we tend to use the term unconscious phantasy and sometimes we mean the *patient's* unconscious phantasy. However we also tend to use the term to describe a mutual unconscious collusion that has been co-created in the analytic setting to make a clinical reality (an enclave or an excursion would be two such creations that will be familiar to most of us [O'Shaughnessy, 1992]). Neville Symington (1983) in his papers on phantasy and the analyst's act of freedom has used the term phantasy in this way, and I think that many British authors have described a similar phenomenon albeit from different perspectives. For example, Joe Sandler's (1976) paper on role responsiveness and Michael Feldman's (1997) contribution on the analyst's involvement in projective identification derive from very similar observations of the clinical process although their theoretical frameworks differ substantially.

The work I have briefly referred to suggests to me that no analyst would claim to be a 'complete container' and hence 'not susceptible to enactment' – I found the idea of such an omnipotent analyst to be something of a straw man in your paper.

I think all the authors I have referred to would share the view that, while these clinical situations are jointly created, their main clinical interest is in the fact that they exemplify the analysand's unconscious internal object relationships, rather than being primarily an artefact of the analytic situation or the analyst's approach to the patient. Most of us consider them to be asymmetrical creations, largely because they are created in an asymmetrical setting in which primacy is given to what is in the patient's mind. I know that you have argued in the past, from a feminist perspective, that the asymmetrical feature we should be more aware of is the asymmetric power relationship that exists in the psychoanalytic relationship. Although you do not directly refer to this previous work in this paper, I think that it still informs your clinical technique and theory about change and hence you argue that a prerequisite of change is that the analyst has to change. A very different view is that the analyst's task is to put into words the nature of the current relationship. Of course, this will require self-monitoring, self-awareness and self-adjustment on the part of the analyst but ultimately change is dependent on the balance of forces within the patient.

There is something else that I want to mention before I turn to discuss in a little more detail your concepts of thirdness and the moral third. The authors I have quoted would agree, judging from the clinical examples they provide, that these co-created clinical situations can as easily be antithetical to healthy relating to self and object, as promoting of it; they can be, amongst other things, restrictive, sadistic and perverse.

Your concepts of thirdness and the moral third are very different. As I understand it, you wish to reserve these terms for a relationship that is governed "by principles of lawful relating, involving accommodation, attunement" and later including "consensus, negotiation and recognition,

especially recognition of the other's separate subjectivity". When the analytic relationship strays from this thirdness the task of the analyst is to understand her or his part in the rupture (I agree) and then attempt to "repair the rupture" and restore this lawful way of relating (I disagree). If I understand your point correctly, then this work of restoring allows a firmer hold on thirdness. While we might agree that lawful relating which recognizes one's own and other's subjectivity is a worthwhile aim of psychoanalysis, I think we may disagree strongly on the means of achieving this.

Let me use your clinical material to illustrate these differences. Before I do so I would just like to state that I am *not* using your clinical material in order to say anything about your actual patient. Rather I am using what we have at hand in order to describe a different approach to draw out the differences between us.

You present a patient who has used her analysis to make very worthwhile progress in her life in terms of becoming a successful professional, a partner and a mother. However, she regularly engages in vicious bouts of self-hatred in which she spirals down (or, I am going to suggest, maybe up) into demeaning herself in comparison to her more successful and attractive colleagues and friends. Your approach is based on your understanding that the patient's mother was uncontainable and could not help the patient process her unhappiness, her neediness and disappointment in herself. Lacking such a container the patient was not able to deal with her self-doubts in any way other than to dissociate herself from them and then indulge in the shameful and masochistic beatings which she can still resort to. Your aim is to provide a container for her sense of unworthiness in order that she can re-connect with her shameful and bad self in a more contained, and hence a more concerned, humane and moral way. A central feature of such containment, you argue, is the demonstration that you yourself can contain and acknowledge your own shame about yourself when you feel you have acted badly. You describe this as a kind of modelling, for example, of being able to survive scrutiny.

A different perspective would be to see the patient as caught up in a sado-masochistic pattern in which she is both the beater and the beaten. You describe this but do not emphasize it to this extent: on the basis of your material one could go much further and hypothesize that she gets a very particular perverse pleasure from this. One could interpret that she is identified not only with Nicole Kidman's victim but also with a murderous Nicole Kidman and that unconsciously she idealizes this identification (hence the raucous laughter). To make use of the title of the film: it's *To Die For*, i.e. she does not care that in indulging this part of herself she does indeed kill the creative work she and her analyst have done. From this perspective the analyst is not just a hapless bystander as the patient beats herself up; she is the victim.

After you finally snap, you underline the need as the analyst to acknowledge your lapse, hence you apologise for your sharpness and then you suggest that the patient should not let you off the hook. Would not another way of looking at the situation be that your sharpness was an unmediated (albeit understandable) response to having your work and achievements as

analyst/mother yet again murdered? You argue that acknowledging your sharpness and your shame about it shows that the analyst can change and hence transforms the analytic process into one of mutual listening. I think I agree with you but not in a very agreeable way! I think it does indeed transform the analytical process and may make it a not so analytical process (in that it may require you to scotomize the main dynamic).

Where I think we might agree is in the view that if one were to take up the patient's sadism and her delight in it, in a very direct way, then the patient could feel blamed, held responsible, shamed, and this could easily lead to the sort of rupture or impasse you feel we should aim to avoid. I think there are several reasons for such impasses but I want to focus on two in particular. The first is that the analyst does indeed convey some sense of blame or disappointment in the patient. But this I think stems from a failure to be psychoanalytical: it comes from subscribing to a moral sense of how things should be, i.e. fair and lawful, rather than a psychoanalytical viewpoint which simply aims to describe things as they appear to the analyst without applying moral judgement. I think this is a very difficult thing to do and it is something that the analyst really has to work on – she or he has to remember that it is the patient's prerogative to be as she or he is, but it is the analyst's responsibility only to describe this, not to make a moral judgement of it. I have found that when one truly does this work inside oneself this sometimes communicates itself to the patient and they are then able to reflect on themselves in a more contained way. The analyst does not need to acknowledge his own work or his faulty and moral stance before the work was done. Indeed such acknowledgement, to my mind, is in itself dubious – has the analyst lost faith in the patient's ability to observe him and draw his own conclusions? After all, as you say in this paper, analysts can be hyper-vigilant so why do they need this acknowledgement? Or does the analyst need to establish himself quickly as the good and moral object?

This brings me to another problem – one that I do not know how to solve. In my experience when one does address the patient's sadism and perversity then it is often the case that a very malignant object comes into view. Sometimes, as I have described, it is the analyst's superego and the way that the patient has drawn out the analyst's insistence on morality. Even when this has been 'tamed', so to speak, in some cases this is not the end of the problem; something in the patient remains very active and stops analytic progress. This might be due to the severity of the patient's superego, they do not deserve improvement, or it might be due to their inability to give up the sublime pleasure they take from their perversity. The analyst can only struggle to describe the exact nature of the bad object (which is sometimes felt to be the analyst or the analysis itself), but sometimes analysis breaks down in these situations. I want to make this point to be absolutely clear that I am not bringing a different approach in order to make an omnipotent claim for its efficacy. I think the sorts of problems that my take on your patient exemplifies are very difficult to treat.

I want to end by agreeing with you that the analyst's constant scrutiny of himself or herself is a vital part of the analytic process. This crucially involves listening to the patient's material as a source of information about

how the analyst is *actually* being as well as how he or she is being transferentially perceived. I think this is a part of a kind of Socratic self-questioning which is essential. It is at its most vital when it gets us to question whether we are being analytical, rather than when it gets us to doubt that we are being moral. I believe that in seeking to be, and to be seen, as moral we may, at times, actually fail to be analytical. Indeed it can be argued that the best safeguard of our morality is our striving to understand the clinical situation from a psychoanalytical perspective rather than a moral one.

References

- Baranger M, Baranger W (2008). The analytic situation as a dynamic field. *Int J Psychoanal* **89**:795–826.
- Feldman M (1997). Projective identification: The analyst's involvement. *Int J Psychoanal* **78**:227–41.
- Ferro A (1993). The impasse within a theory of the analytic field: Possible vertices of observation. *Int J Psychoanal* **74**:917–29.
- Ogden T (1994). The analytic third: Working with intersubjective clinical facts. *Int J Psychoanal* **75**:3–19.
- O'Shaughnessy E (1992). Enclaves and excursions. *Int J Psychoanal* **73**:603–11.
- Sandler J (1976). Countertransference and role-responsiveness. *Int Rev Psychoanal* **3**:43–7.
- Symington N (1983). The analyst's act of freedom as agent of therapeutic change. *Int Rev Psychoanal* **10**:283–91.