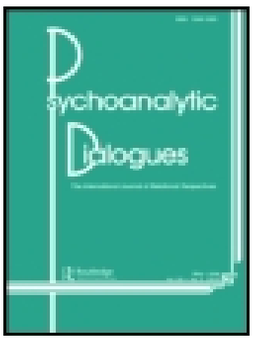

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Moments of Therapeutic Impasse

Commentary on Jody Messler Davies's "Whose Bad Objects Are We Anyway? Repetition and Our Elusive Love Affair with Evil"*

James L. Fosshage, Ph.D.

Davies contributes to the development of relational theory by formulating and illustrating what occurs during especially difficult moments in an analytic exchange. In understanding enactments, Davies importantly underscores the contribution of both the analyst's and patient's "bad objects." This author attempts to build bridges between Davies' language and concepts anchored in object relations theory and this author's language and concepts based in contemporary or relational self psychology, including the integration of cognitive psychology. In addition, this author delineates the use of the "empathic," "other-centered," and "analyst's self" listening/experiencing perspectives to explicate the case material and to provide alternative understandings and pathways for psychoanalytic work. The thesis set forth is that the use of different listening/experiencing perspectives expands choice for the analyst when working in difficult moments of the clinical exchange.

TAKING US INTO THE INNER SANCTUM OF AN ANALYTIC PROCESS, JODY Messler Davies has provided us with an unusually rich and evocative paper on intense moments of therapeutic impasse. Davies contributes to the development of relational theory through formulating and illustrating what occurs during especially difficult moments in an analytic exchange.

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* "Whose Bad Objects Are We Anyway? Repetition and Our Elusive Love Affair with Evil" by Jody Messler Davies (2004) appeared in *Psychoanalytic Dialogues* (14/6).

Jody Davies, like most of the well-known American Relational authors, uses concepts and a language—for example, bad and good objects, projective and introjective processes—that are anchored in object relations theory.[1] In contrast, my concepts and language—for example, expectancies or organizing patterns, implicit and explicit learning, repetitive and selfobject transferences—are anchored in contemporary or relational self psychology, intersubjectivity theory, and cognitive psychology. Herein lies the challenge—to build bridges between languages and concepts to compare, evaluate,and synthesize (Fosshage, 2003).

Countertransference and Listening/Experiencing Perspectives

To set the stage to address Davies's case material, I first focus briefly on the issue of countertransference and listening/experiencing perspectives (Fosshage, 1995a, 1997). To define countertransference as the analyst's experience of the patient—what is called the totalist perspective (Kernberg, 1965)—makes clear that all analysts of whatever persuasion use countertransference or their subjective experience to understand patients, for what else is there? Whether or not an analyst uses subjective experience thus is no longer the relevant question. Instead, the interesting issue is what are the factors that influence analysts' countertransferences that contribute to differences in analysts' experiences of patients?

The analyst's listening/experiencing perspective is among the important variables that significantly affect countertransference, as I have proposed (Fosshage, 1995a). The *empathic perspective* refers to listening and experiencing, as well as possible, from within the frame of reference of the patient (Kohut, 1959, 1982). Empathic listening is filtered through the analyst's subjectivity via affect resonance and vicarious introspection. The *other-centered perspective* refers to an analyst's experience of a patient as "an other" in relationship with the patient—what it feels like to be an other person in interaction with

[1] The term *relational* is used in two ways: (1) to reflect an ongoing change in paradigms that includes a number of psychoanalytic approaches, and (2) to refer to a relatively cohesive group of principally American Relational psychoanalysts (see Fosshage, 2003).

the patient. While the empathic perspective potentially informs us about the patient's experience, the other-centered perspective potentially informs us about the patient's repetitive or newly emergent interactional patterns (Fosshage, 1995a).

All analysts *variably* listen and experience from an empathic perspective. Self psychologists, with the exception of Lichtenberg (1984) and me (1995a, 1997), have recommended its consistent usage on which to base intervention. American Relationalists, in addition to using the empathic mode, often meaningfully use experience emanating from the other-centered perspective to serve as the basis for understanding and responding. Davies's clinical illustration presents a moment during which the analyst's other-centered perspective was in the forefront in the analytic work. These alternative perspectives profoundly impact the analyst's experience and understanding of the patient, creating very different clinical moments. In my view (Fosshage, 1995a, 1997), the variable use of both perspectives deepens our understanding of patients and their relationships. An overriding use of the empathic mode helps us assess how and when to use information from each of these perspectives therapeutically.

Whereas empathic and other-centered perspectives are focused on the patient, all analysts variably use a third perspective, what I have called the *analysts's self-perspective*, referring to the analyst's self-experience (Fosshage, 2003). For example, in attempting to understand who is contributing what to a particular patient–analyst interaction, an analyst assesses, as well as possible, his or her experience and contribution to the interaction. Recognizing and using these three perspectives, in my view, substantially facilitates clinical work.

Jody Messler Davies's Clinical Material

Davies's clinical narrative begins on a Thursday afternoon when Davies, with a sore throat and terrible head cold, finds herself irritable and wanting to be home. Warily anticipating her next patient, who "was never easy," Davies greets Karen in the waiting room and with a sinking feeling notes Karen's face, which was "particularly stormy and brooding even for her." Karen spoke the first words with "half complaint, half admonishment . . . 'You're still sick?'" (p. 712). Karen seized the opportunity, adding, "I can't believe you haven't shaken that thing yet" (p. 712). Karen's provocative remark, as with all such

remarks, triggers the other-centered perspective in her analyst, for Davies immediately feels the impact and "knows" what it is like, when feeling physically ill, to be in a relationship with Karen. Under such an attack, she feels momentarily "slow and stupid" and "immunologically inept" (p. 712).

Importantly, Davies "chooses" to live in that moment, in this other-centered space, feeling the interpersonal repercussions of Karen's attack. Choice in enactments (what I define as especially poignant interactions that range from negative to positive affect; Fosshage, 1995b) are delimited by how gripping and how conscious or unconscious the interactions are, how intense the affects, and by the themes and meanings for both patient and analyst. The analyst's choice expands, in my view, with the awareness and potential use of three listening/experiencing perspectives. For example, when we are angry in reaction to a provocative patient, we can use our other-centered experience and address directly the patient's provocation. Among the myriad of meanings for the patient, the analyst's intervention, in these instances, might assure the patient that the analyst will not avoid anger or might engender a sense of being criticized. We can also choose to shift momentarily to an empathic perspective, enabling us to understand the patient's experience that gave rise to the provocation. Shifting to an empathic perspective might create more reflective space for both patient and analyst. The analyst subsequently might offer a comprehensive understanding of the interaction, starting on the inside with the patient's experience and ending with the patient's provocative behavior. On the other hand, shifting to an empathic perspective might not be possible for the analyst until the provocation is addressed, or might convey an unwillingness to stay in the heat of the interaction.

Davies reflects about what is happening to her in the interaction with Karen. Experiencing what it feels like to be ill in a relationship with Karen (other-centered perspective), Davies also empathically tunes into Karen's intense hatred (that is, Karen's experience) toward an "incapacitated" caregiver.[2] At this moment, however, she does not

[2] During a dialogue on February 8, 2003, at an Institute of Contemporary Psychoanalysis of Los Angeles conference entitled, "Therapeutic Impasse and Trauma: The Reflections of Three Psychoanalysts: Jody Messler Davies, Ph.D., Robert D. Stolorow, Ph.D., James L. Fosshage, Ph.D.," it became clear that Davies was listening and experiencing from both other-centered and empathic perspectives, while initially privileging, during this clinical moment, other-centered experience as the basis for her interventions.

attempt to explore from an empathic perspective the meanings of Karen's reaction to her illness. Instead, she capitalizes on the opportunity of living in the "bad object"relational embroilment. Having established sufficient safety to risk being in this interactional space, patient and analyst "glared at each other in silent rage: both of us from places we knew; both of us from places we hated within ourselves" (pp. 713–714). Davies describes this as a moment of therapeutic impasse and "a moment of profound mutuality and engagement as well" (p. 714). She delineates her theoretical position:

> It seems to me intrinsic to relational thinking that these "bad object relationships" not only will but must be reenacted in the transference-countertransference experience, that indeed such reenacted aggression, rage, and envy are endemic to psychoanalytic change within the relational perspective. . . . To evoke the bad object relationship without concretely becoming the bad object . . . to invite the reemergence of traumatic histories of affective intensity and pitch without being swallowed up and destroyed by them seems to be our most complex therapeutic challenge [pp. 714–715].

Davies, like other American Relational authors, privileges repetitive enactments as providing the primary springboard for analytic work and change. Reenactments of bad object relationships, in her view, are "endemic" to psychoanalytic change. While enactments are too often viewed as initiated solely by the analysand, remnants of a one-way influence model, Davies importantly offsets this tendency and fills out the relational model as a bidirectional influence model in declaring that enactments are complex, involving self-states, expectancies, and bad objects of *both* participants. Moments of therapeutic impasse emerge out of the interaction of both the patient's and the analyst's bad objects (in my language, the activation of traumatic themes in both patient and analyst).

While activation of analysts' traumatic themes can diminish capacity to shift experientially among other-centered, empathic, and self perspectives, analysts often retain this capacity and can choose sequential use of other-centered, empathic, and self perspectives for intervention. In this clinical moment, Davies chose to privilege other-centered experience and to live in the relational embroilment, empathically sensing that this provided the most effective avenue for

Karen to experience and understand her hatred. As an alternative, we might choose to hold our other-centered experience for later use and to move into empathic inquiry. Intervening from an empathic perspective would have led us initially to inquire about and collaboratively reflect on the meanings and origins of Karen's anger. Her analyst's illness, as Davies later makes clear, triggered a traumatic theme related to Karen's experience with her depressed mother. Karen apparently fearfully and angrily expected that her analyst's illness, like her mother's depression, would prevent her analyst, like mother, from taking care of her. Perhaps even more frightening and enraging to Karen was her anticipation that her analyst, like mother, would reverse roles, forcing her to take care of her analyst. When feeling attacked by Karen, Davies (like most of us) was prone to experience Karen's request for a change in the schedule as a demand, triggering an aversive reaction. From an empathic perspective, however, Karen's request for an earlier appointment might be experienced and understood as a partially concealed, perhaps even desperate, attempt to get the analyst to take care of her, to reassure herself that the analyst, unlike mother, was still capable of caretaking. The very act of the analyst's empathic inquiry could have conveyed that Davies, unlike her mother, was able to function and, rather than require Karen's administrations, could still focus on Karen despite her illness—leading to new implicit procedural learning. At a subsequent point the analyst, using other-centered information, could have delineated a primary relational pattern in which Karen's intense aversive reaction to her analyst's illness, understandable in light of her history, provoked, in turn, the analyst's aversiveness and unavailability, creating a constricting negative relational scenario.

Anchoring the analyst's inquiry and responses in an empathic listening/experiencing perspective would, of course, have created a different interactive moment. I am not suggesting that it would have been a better moment, but only that it would have been a different moment. These are alternatives to reflect on, experiment with, and assess. After all, Davies (with her masterly skill) and Karen (with an undaunted determination to express herself) were a remarkably successful analytic dyad, in that they struggled and found their way through the bad object impasse to cocreate growth. The challenging question with regard to these two alternatives, however, is what might have been gained and what might have been lost, keeping in mind

that there are a number of roads leading to Rome, albeit perhaps to different parts of Rome. In my view, living in the enactment as Davies did enabled the patient to fully experience her hatred, to be later understood and accepted. Tarrying too long, however, risks replication versus transformation of the traumatic experience. Empathic inquiry, through understanding as well as through the interactive process, can also transform traumatic experience, as previously delineated. Not living long enough in the enactment and turning to empathic inquiry too quickly, however, can convey a message of discomfort with and unacceptability of, in this instance, the patient's hatred, increasing the difficulty in integrating and transforming the affective experience.

How do Davies and Karen transform this impasse, this mutual glaring at each other in silent rage? Initially Davies finds herself, and senses the same for Karen, attempting to recall the positive caring and nourishing memories with one another—efforts to self-regulate. Karen, however, confronts her with piercing clarity, "You're such a bitch. You're cold and unfeeling. . . . The least you could do is to admit it" (p. 715). "Parallel" to the attempt by her "therapeutic self" to understand and work with Karen's hatred, Davies reflectively describes her *self-perspective*:

> What is most significant, I believe, is that we have reached a place together in which I hate the self that I have become with her. I AM the bitch she describes, and I am horrified and chilled by the ice that lies below the surface, hardening over the well of good intent and affection that at other times defines the more loving relationship we "also" have [p. 715].

Reflectively open to her other-centered and her self-experience, Davies perceives a complex intersubjective interaction. She then, adding an empathic perspective, recognizes that Karen "is hating herself as well . . . and all the time deeply ashamed and frightened by its internal tyranny" (p. 716). Then a "moment of meeting" (Stern et al., 1998) occurs. "You hate me," says Karen. Davies responds, "Mhmm . . . Sometimes we hate each other, I think. Not always, not even usually, but sometimes we can get to this place together. I guess we're gonna have to see where we can get to from here. Neither of us likes it much; it just is." "Yeah," said Karen, "it sucks." Davies replies, "Yeah, it does"

(p. 716). What begins as Karen's fear of her analyst's hatred Davies enlarges in an open acknowledgment of times of mutual hatred, thereby making neither a victim and facilitating the acceptance and integration of moments of hatred.

Repetitive enactments range in difficulty related to the variability in intensity of the patient's and analyst's repetitive themes. At times, evocation of the patient's traumatic themes does not jeopardize the analyst's reflective capacity. In contrast, heightened moments of impasse in which the patient's traumatic themes evoke those of the analyst create the greater challenge in managing "the emergence of our most secret and shame-riddled 'bad selves,' our own and the patient's" (Davies, p. 717). These instances can momentarily jeopardize our reflective capacity. In Davies's treatment of Karen, activation of bad selves in each created a momentary impasse, but one in which Davies chose to live. Davies's ability in this instance to reflect, openly acknowledge, and empathically accept the bad selves of each, diminished the hatred and shame and created a pathway out of the impasse.

With patients traumatized in childhood, Davies feels that "the analyst . . . *must* be both the object of the patient's transferential rage over abuse, abandonment, and betrayal, as well as the one who helps the patient contain, soothe, modulate and ultimately come to terms with such experiences" (p. 717; italics added). No one escapes trauma during childhood; yet trauma varies widely in intensity, severity, repetition, and posttraumatic responsiveness. On those occasions when the analyst's repetitive problematic patterns are not evoked, then we can live in the attributions of the transference (Lichtenberg, Lachmann, and Fosshage, 1996). With these patients we can reflect and more comfortably, as Davies puts it, be "in the moment" and "out of it" at the same time (p. 719). In the more severely traumatized patients, however, the intensity of repetitive themes of abuse, abandonment and betrayal will more easily evoke the analyst's traumatic themes, creating poignant enactments that can potentially become nonnegotiable therapeutic impasses (Pizer, 1998).

Must the patient's bad objects or traumatic themes be evoked in the analytic relationship? Davies is unequivocal in her position that they do; I take a more circumstantial position—not necessarily. Evocation of a patient's traumatic themes in part depends on the analyst's contributions. To expect all of a patient's primary traumatic

themes to be evoked in the transference implicitly minimizes the analyst's contribution. Even more troubling, it assumes that a patient is more riveted to his or her patterns of organization (that is, the activation of the patterns would occur regardless of who the analyst as a person is) than in fact the patient may be (Fosshage, 1994). In my view, traumatic themes can be meaningfully analyzed with whomever they are evoked, and it is best to make no assumptions about their required activation within the transference. It is likely but not necessary that traumatic themes will be evoked in the analytic relationship.

In resolving a therapeutic stalemate, Davies emphasizes that "both badness and goodness can be jointly held and experienced together" (p. 724). To accomplish this, the patient must "give up seeing this badness as residing exclusively within herself. Then and only then can she believe in the analyst's actual rather than total and projected badness, and only then can she see the process of her own projection without blinding shame" (p. 724). In my language, the analyst's acceptance and candid acknowledgment of his or her contribution to the stalemate enables the patient not to feel blamed for the impasse. Not having to protect against an anticipated denial, the patient in turn becomes less aversive, more reflective, and more capable of owning his or her own contributions. Alternatively, an analyst's attempt to explore prior to acknowledgment of the analyst's contribution can easily be experienced as a defensive evasion, implicit blaming, and invalidation, most likely replicas of the patient's traumatic past. In ferreting out a patient's and analyst's variable contributions to the patient's experience, the analyst's acceptance of his or her contribution, no matter how small, opens up reflective space for both patient and analyst.

When Karen enters the Friday afternoon session, she is in a different state of mind. Davies's acknowledgment of a mutual hatred at the end of the previous session helped Karen to accept her hatred, diminishing her shame. Feeling warmly caretaking of her analyst, Karen now brings Davies a healing brew. Davies warms immediately and receives the mug with its hot tea, milk, cinnamon, and honey. Karen says straightforwardly with an implicit recognition and exploration of Davies's subjectivity, "You look lousy," and Jody responds in kind, "I feel lousy," but this time with a smile. Karen "is noticed and appreciated in that moment. She has dared to enter my world and she

finds herself welcome there" (p. 726). Karen is able to empathically enter Davies's world. Karen and Davies are able to reconnect, to reestablish a mutual selfobject or vitalizing connection (a vitalizing enactment). Reflective space enlarges. For further exploration, Davies reintroduces "those two other people who were in here yesterday" (p. 728). Karen reiterates that Davies hates "that me." Davies openly and candidly acknowledges it again, but adds to the mix her even more painful hatred of herself, sharing her struggle with these shame-ridden aspects of herself. Both are able to share and own their respective good and bad aspects.

The ongoing transformation of Karen is poignantly conveyed in her dream in which the mechanical, extraterrestrial creature is tearfully expressing a need for help. Hesitantly and painfully Karen reaches out and sees that the being is grieving and is becoming human. To become human again despite powerful derailing trauma is a potent motivational thrust, poignantly depicted in Karen's dream. Clearly Davies and Karen are successfully navigating the rapids, cocreating a powerful humanizing experience.

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