

Terminations, Self-States, and Complexity in Psychoanalysis:

Commentary on Paper by Jody Messler Davies



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In this paper I discuss the theoretical and clinical implications of the termination process with Jody Davies and her patient, Karen, in which the revisiting of self–other configurations and their corresponding meanings, having evolved over the course of treatment, are explored. The discussion highlights, from a complexity theory perspective, the themes of emotional honesty, uncertainty, capacity to mourn, and self-agency in the context of multiplicity of self.

I am delighted to be able to share my reactions to Jody Davies's (2005) evocative article on termination and its emphasis on the ongoing dramatic interplay of previously inhabited self–other configurations and experiences. In treating us to such a rich perspective on human relating, inviting us to the hearth of who and how she is clinically, Davies addresses essential and vital aspects of the analytic relationship that are inevitably revived, revisited, and amplified in this pivotal moment of an analysis. In this sense, termination, for Davies, is about connections, losses, endings, and mourning, yes, but I think much more about the powerful revival and revisiting of rich, colorful, multiple self and other configurations that have come to coalesce and organize emotional meaning during the course of an intimate relationship.

Davies asks us to imagine a relationally designed psychoanalytic tapestry, one reflecting the inevitable complexity of the interweaving of multiple self-states that emerge between two or more people. She also asks us to imagine that these multiple self-states are “developmentally organized systems

of identifications and counter-identifications” (p. 783; in the Rackerian sense) and that these organized systems are what create emotional meaning in the context of our relationships. I can myself easily imagine this tapestry, one in which I too live and breathe, and struggle, daily with my patients. I understand these experienced self-states to be necessarily and always intersubjectively or systemically derived, highly context dependent and context sensitive.

One of my own preconceptions, emanating from my interest in complexity theory (Galatzer-Levy, 1978; Sashin and Callahan, 1990; Spruiell, 1993; Thelen and Smith, 1994; Stolorow, 1997; Cilliers, 1998; Ghent, 2002; Coburn, 2002; Sander, 2002; Seligman, 2005), is that any specific self-state I may experience *in* my patient or *in* myself is not really *in* anything but rather distributed across a broader relational context of which my patient and I are adaptive constituents. This preconception highlights the crucial distinction between how and what we experience and that which gives *rise* to the experience, a distinction of necessity if we are to avoid the conceptual confusion inherent in many of our theoretical and clinical dialogues. I refer here to the distinction between what is experienced, on a variety of levels of consciousness (Stern, 1997), and the dynamic, unpredictable interplay of the multitude of interpenetrating adaptive relational systems that give rise to such experience. All by way of saying, it is useful to know on what level of discourse we are speaking from one moment to the next, or, perhaps, which side of the tapestry we are employing—the *phenomenological* or the *explanatory*. Explanatorily speaking, I understand a “self-state” to be a dimension of experience that is emergent and always *of* a context and that it is always a product and a property of a larger relational/historical system.

Davies (2005) tells us that “each good-bye between analyst and patient holds the potential to define the entire experience of the analysis and to determine how that experience is remembered and held over time” (p. 783). I would add, it is likely to be defined by (or organized by) the entire experience of the analysis *prior* to its ending as well. This reflects the concept of *scaling* or *self-similarity* in complexity theory—that is, characteristics of relational systems are not *represented* exactly in a single component but rather are *reiterated* throughout all components of the system over time. (Think of those beautiful computer-generated images, based on fractal geometry, in which patterns are repeated but on a different size and temporal scale.) This is reiteration, not representation or repetition. I imagine the emotional soul-searching and, ultimately, honesty clearly evidenced in the ending phase of the treatment between Davies and Karen reflect a relational

pattern that had been an emergent property of the entire relationship over time. Clearly, emotional honesty is not new to this pair!

I would like to distinguish here between emotional dishonesty and what Davies refers to as “the projective disavowal of unacceptable self or affect states” (p. 783), which is a different realm altogether. In regards to the latter, I assume that aspects of self, other, and self-with-other affective potentialities are always being dissociated or disavowed, either as a function of the anticipated danger inherent in the affectivity involved or simply as a function of the inevitable foreclosure of one dimension of experience in the process of the emergence of another (see Stern, 1997). Emotional *dishonesty*, on the other hand, reflects the relative absence of an attitude essential to psychoanalytic practice. Its inverse, emotional honesty comprises an attitude of openness and sustained inquiry, one that says, to the best of my current knowledge, this is what I think, feel, believe, or understand but also that I recognize that I, you, and we live within realms of varying degrees of consciousness, ranging from the explicit to the implicit to the nonexistent, and that as honest as I try to be, I presume I cannot know all of what is going on.

Aron (1996) spoke of this in his discussion of the process and ramifications of self-disclosure in psychoanalysis. Of importance (as reflected in Davies's case) is not just the presence of emotional honesty (which I assume we understand does not mean in any way wholesale verbal self-disclosure) but also and in particular the experience of *struggling* to be honest, to really show up. I believe this is what Davies means by “allowing Karen to see the complexity of my own motivations” (p. 790), allowing her to witness Davies's—and this is pivotal—*attempt* to metabolize her own destructiveness and shame. This is not clinical perfection I am speaking about: It is a willingness to struggle. I think Davies provides us, not for the first time in her body of work, a beautiful example of emotional honesty in her description of her and her patient's exchanges around the at-first not-so-explicit feelings of rejection and abandonment. I believe, as I think Davies does as well, that this struggle with emotional honesty, the working hard not to disavow what was initially only felt around the edges and margins of her experiential world, is an essential ingredient in therapeutic action. But in addition to emotional honesty, Davies and Karen find themselves capable of holding—in other words, *not* dissociating—seemingly discrepant and conflicting self-states, out of which emerges the experience of making a painful decision felt to be one's own, one that is *mine*.

What does it mean, exactly, to make a decision that is considered *mine*? At one particularly pivotal juncture, Davies, having previously reflected

on her self-states and quickly contextualizing her reactions and feelings, circumvents a “deepening enactment and mutually regressive transference–countertransference impasse or stalemate” (p. 800). She felt far less shame, having attributed her reactions to her “younger” self-states. In this instance, the awareness and the hierarchical organization of these different self-states or “littler parts of me” replace what could have been dissociation and disavowal. Davies continues that “those little ones of mine aren't running the show” but instead “this decision [not to attend Karen's wedding in California] is *mine*” (p. 801).

I infer from Davies's work that a decision that is *mine* is one in which as many multiple and conflicting self-states as possible are taken into account—meaning: felt, embodied, lived, taken responsibility for, and then hierarchically organized. The issues of responsibility and of hierarchical organization are especially important. The one about responsibility is a tricky one, and one that reflects a quintessentially human struggle of great proportion—that is, the clinical, and human, necessity to take responsibility for something that ultimately one, individually, cannot possibly *be* responsible *for*. In one sense, Davies, like her patient, cannot be held responsible for her child parts, for the multifarious dimensions of her self-experience. They just are. Davies did not create them; she did not wish for them or conjure them. They are the property and product of a larger historical, relational system of which each of us is simply, and complexly, an adaptive constituent. However, in another sense, that is exactly what Davies must do (as evidenced in her clinical exchange): She *must* take responsibility for them because, in the phenomenological sense, they *are* hers; they belong to Davies and to no one else. I think this reflects one of the paradoxical ironies of what it means to be oneself, as analysts and as people in general, that we at once need to take responsibility for that which ultimately we cannot be held responsible (even though we often are).

Thus, speaking of responsibility, I think the clinical elegance here lies in Davies *extending* her willingness to be emotionally honest—what she had helped her patient do for many years—into the realm of living in uncertainty. This is beautifully illustrated in the exchange in which Karen asks, “How can you be so sure?” to which Davies responds, “Well I'm not sure, but to the extent that I feel confident enough, it's because the decision is making me miserable” (p. 801). Here Davies simultaneously captures and embodies dimensions of her experiential world that at first emerged at the edges and margins and that, with effort, were retrieved, taken responsibility for, and eventually articulated. And perhaps more important, the character of her verbal expression of what were the edges and margins reflected an

identifiable *uncertainty* that was, I believe, one essential ingredient in what was therapeutic. Thus, and in other words, what is usefully and dialectically balanced at this juncture is Davies's willingness to know and articulate something essential of herself while communicating that she can't possibly fully know herself. This is the “to the best of my knowledge” attitude to which I had referred earlier—it is the taking responsibility for that which one did not create on one's own, and for that which one cannot know fully, but that, phenomenologically, and including the inevitable uncertainty, now must *be* one's own.

Equally critical, this exchange sheds light on additional ways we might conceptualize the nature of dissociation. Whereas the *mine* that Davies speaks of clearly encompasses a consideration of (or the taking into account) many of the hard-won parts of herself, paradoxically the *mine* also reflects a consciousness that is not whole and integrated exactly, one that does not disavow “child parts” and yet one that in and of it self is not singularly controlling things. To my mind, this suggests a different type of dissociation in which we choose to recognize and take into account a ‘part’ of our self and at the same time assert that it is not running the show. What exactly is *being* dissociated, and when invited into awareness and articulated, in what way and in what proximity do we hold these parts—what relationship do we maintain with them? The answers that emerge in the course of our clinical work with a specific patient, it seems to me, will determine how we relate with each other, with each other's “parts,” and the relationship our patients will have to the variety of dimensions of experience they discover within themselves and in relation to others. They will also determine our sense of agency. In Karen's situation, she clearly has drawn from her treatment with Davies a sense of the degree to which she needs to let her “child part” live and breathe. She knows the necessity of this, and also senses, considering her new life context, the potential of this child part being snuffed out.

Thus, I think another essential therapeutic ingredient in this particular termination process was not just the experience of taking responsibility, as previously discussed, but also the hierarchical organizing of the variety of self-states present and the use of this organization by which clinical and relational decisions were made. Implicit, if not explicit, in this organization is the dyadically constituted *value*, or culture, evolving over time that says, in effect, given all my self, other, and self–other configurations, I (the I of the *mine*) can have agency and choose that it is better to desire and to know loss, to celebrate and to grieve.

Complexity theory posits that consciousness or experience requires the interface of an object and a subject and that, paraphrasing **Taylor (2001)**,

each emerges in and through the other, and therefore neither (nor both) can be reduced to the other (or to either one). In that light, I assume that Karen's "self-states" were as much a property and product of Davies's experiential world (including her historical world) as they were of her own.

Explanatorily, this vision of human experiencing collapses the notion of projective disavowal of what is felt to be unacceptable. I don't believe one can project or rid oneself of something that is not ultimately attributable to that person or "owned" by that person to begin with. All attributions are relational and contextual in the sense that they are not the product of individual minds but rather coalesce in the field between them. And yet, to communicate dialogically and to engage in meaning making, we inevitably speak in the phenomenological language of individual minds, which entails and necessitates a kind of parsing out of emotional experience, that is, this is how I am and this belongs to me and this is how you are and this belongs to you. Whereas these particular distinctions are essential to good clinical practice, I believe problems arise when we take the phenomenological as the explanatory and forget that we would not even be having these experiences, and feeling our convictions, if we weren't all in this together.

I think the beauty of Davies's work is that she acts and speaks phenomenologically with and to her patient and yet, at the same time, does not hold her patient solely responsible for systemically derived phenomena. She conveys to her patient, phenomenologically, that yes, I too have these parts to me, I too can be injured, I too can wish to retaliate, I too have been seduced and dropped, and also, and importantly, I too can grasp from the edges and margins of my emotional life aspects I'd rather not have to embody and talk about. And this proves quite mutative for Karen, as it did prior to the termination phase of treatment (Davies, 2004).

More broadly speaking, I am especially drawn to Davies's assertion that, unlike in what might be found in a classical analysis, "the significant emotional engagement and participation of the relational analyst could, in the end, leave particular patients extremely vulnerable to an experience of having been seduced and then abandoned" (p. 784). This is profound. It, if generalized to a broader view of life experience, reflects what it means to be fully human, to live one's life to the fullest, to embody deeply one's own life context. Meaning, to be emotionally engaged and to participate in life also means to live with the inevitability of its ending, without the curse or the luxury (depending on your view) of dissociating death from life. To be seduced by life and to allow oneself to slip into the recesses of, and to be penetrated by, the pain, ecstasy, and the inevitable boredom, means also being relentlessly dogged by the oblivion that awaits us. To engage in life, to engage

fully with others, means, essentially, allowing oneself to be ridden hard and put up wet, as they say in the Southwest. *Karen* did this to Davies at the termination phase of treatment by, well, terminating, by developing and having a life of her own and moving on. *Davies* did this to Karen by having offered a relationship Karen could not have refused, one in which Oedipal victories would be won and, importantly, lost—a kind of winning and losing about which Davies has written extensively—one in which their affective horizon broadened to encompass the space, as Davies says, “between desire and despair [where] mourning and acceptance can give way to new beginnings” (p. 803).

In the broader spectrum of human life, Davies's presentation highlights for me my own struggle, and that of many of my patients, of attempting to live life in the space created by my desire for life, on one hand, and my despair at having to relinquish it, on the other hand. One of our greatest challenges, to draw from Davies's words, is “to learn how to sustain desire for that which we [ultimately] cannot possess” (p. 789). It seems to me that Davies and her patient have accomplished that, and more. So, in pondering again Davies' question, “*why indeed?*” I'm reminded of King Lear and imagine the alternative to caring so much: “Oh, that way madness lies”

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Article Citation [\[Who Cited This?\]](#)

Coburn, W.J. (2006). Terminations, Self-States, and Complexity in Psychoanalysis. *Psychoanal. Dial.*, 16(5):603-610