CASE EXCERPT
from

Clinical Integration and Thirdness: A Discussion of Difference, Supervision, and Power

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Christina's Case

Rachel, a 24-year-old, White, female patient of mine, was self-referred to address her emotional distress and reactivity, which was often expressed through relational upheavals, impulsive decision making, and self-harm. Growing up with significant family turmoil, including neglect and possible sexual abuse, Rachel reported instances of unwanted and coerced sexual interactions during her early life. While she denied those instances included rape, she stated that she could only trust men because she was bullied by female peers in her childhood. However, her relationships with men were rocky, and she often engaged them through dating apps in response to her feelings of emptiness or loneliness. These relationships became sexualized quickly, as she desperately wanted to feel desired by men. Moreover, whenever conflicts arose in her family, she would engage in self-harming behaviors (e.g., pinching and punching herself) to alleviate her distress. In the initial stages of our work, Rachel exhibited high levels of distress and emotional dysregulation, and we focused on managing an ongoing self-harm crisis. One session, during this phase of the treatment, Rachel asked me for a doctor's note recommending she be allowed to use her skateboard in the common areas of her apartment complex. She explained that skateboarding was one of the ways she coped with her impulse to engage in self-harm and overcome her feelings of deep loneliness and void. The management of the complex had specific restrictions about what types of activities were appropriate in the area shared by all residents. Despite the presence of local parks and safe areas readily accessible for her to ride her skateboard, Rachel insisted that riding her skateboard close to her residence was safest. Uncertain what to do at the time, I deferred her request and redirected the conversation by exploring the distress that led her to this appeal.

Nine months into our work, Rachel requested I help her gain access to skateboarding again, and this time she included me in an email to the property management and security firm of her apartment complex. While I had gained a much better understanding of Rachel's problems and established stable therapeutic relationship, I was even more conflicted and unsure about engaging with her request and felt stuck and perplexed in response to her email. At this time in the treatment, I was experiencing Rachel as somewhat unruly and disorganized, and I was especially cautious of her unfiltered way of expressing anger in the room. While she never directly targeted her anger at me, Rachel often raised her voice and exhibited pressured speech that overwhelmed me and triggered my anxiety. My passivity and withdrawal in the face of her anger appeared to comfort and regulate Rachel, and for months this pattern continued without examination. Therefore, the re-emerging skateboard request left me in unchartered territory. I feared making a decision that could provoke her, causing me to face her rage and angry outbursts more directly. Feeling pressured and limited in my ability to critically explore and respond to her

request, I automatically planned on contacting Dr. Bland and, subsequently, foreclosed on any thoughts or exploration of my opinions and judgments on this manner. I was not conflicted or unsettled by my natural disposition to seek the mind of the other, and I calmed my uncertainty by thinking to myself, "How could I decide on something where the liability will ultimately land on Dr. Bland? I do not know enough about the implications of skateboarding at her apartment or the reasons for the restrictions. I probably don't see everything that needs to be considered in this situation."

After reading my patient's email, I contacted Dr. Bland to consult with him regarding Rachel's request. On the surface, I was doing what any ethical supervisee would do—calling my supervisor and seeking his clinical judgment and thoughts on an issue that may have significant ethical implications. While this process was sound and developmentally appropriate, I was not acknowledging or confronting my experience of restricted freedom to think and bring in my own opinions on this manner. Later in my consultation with Dr. Bland, he expressed that he was not inclined to say yes and felt that this was not something that was appropriate for us to provide for my patient. At that moment, I experienced significant dissonance, where I was thoroughly confused and unconvinced by his response, but wanted to believe that his decision was valid. Even before he explained his opinion on the matter, I reacted with an almost dissociated, "Okay, will do." While I depended on his confidence, I also felt unsafe in his self-assertion, knowing that this would not be received well by Rachel, and I would have to figure out how to communicate this idea without facing her wrath. I could not recognize in the moment that being in the middle of two strong and opposing opinions felt uncomfortably familiar and I noticed myself immediately defaulting to my "no-self" state.

Growing up, the middle was the most uncomfortable, yet the safest, place to be. My position as negotiator was internalized and reinforced on various levels as I took on the role of a mediator in my parents' relationship and the relationship between my parents and sister. As a child, I quickly understood the nature of their conflicts, and I saw ways to alleviate the tension between two strong voices by becoming the person that each person wanted to see in the other. For instance, I was an affectionate partner to my mother, competent partner to my father, compliant daughter to my parents, and compassionate caretaker for my older sister. Self was a scary state to possess, and my seemingly amorphous sense of self took the shape of whatever kept me safe in the moment. Ultimately, assuming the role of the mediator allowed me to disavow any part of myself that could put me at risk of being the target of shame, rage, chastisement, and rejection. Therefore, in the interaction with Dr. Bland, I found myself in a familiar state of unrecognition, mirroring the safest and most secure thoughts and opinions to keep this situation from wreaking internal havoc. Although it was unconscious in the moment, I wanted to protect myself from being the subject of my patient's anger by conveying my supervisor's thoughts and not mine. As a result, after I discussed the situation with Dr. Bland, I decided to rely on his judgment and deny her request.

Later that week, as I walked outside of my office into the hallway to greet my patient, I found myself rehearsing what to say and preparing myself to defend against any pushback and rage. As soon as I saw the patient in the waiting room, she asked, "Did you get my email?" I immediately responded, "Let's talk about that in the room." The patient trotted lightly into the room with a huge smile on her face, while I took slow and heavy steps, trying to internalize Dr. Bland's

voice. As we settled into the room and the words left my mouth, I saw my patient's facial expression quickly shift from a giddy child to a hostile one. Her arms were tightly crossed, brows furrowed, and lips pouted. She murmured, "This is not fair!" and, as expected, she started to release her frustrations and anger as she elevated her voice and blurted out provocative words. At that moment, I noticed my body tensing and freezing and frantically looking for an escape. I tried to recall everything that I talked through with Dr. Bland. I saw my patient becoming progressively rageful, and I listed all the ethical and empirical reasons as to why we could not grant her the request. However, nothing worked, and I felt her anger occupying more space in the room. At one point, when I was no longer able to stand being the target of her fury, I used the *supervision card* as my last resort to escape her wrath. In that moment, I felt that I relinquished control and let the person of my supervisor face my patient. In response to this deflection, my patient demanded to see Dr. Bland because she felt that she needed to directly confront him for her voice to be heard. As this tension persisted, I eventually caved in and let her know I would continue to discuss this with Dr. Bland and find ways we could best support her within reasonable limits.

I came out of the session tattered and worn out. While I had endured the rage of my patient, my anticipated dread did not stop after my session was over. I felt a deep sense of guilt at the thought that I used Dr. Bland as a shield from my patient's rage. This led me to anticipate his shame and rage in our next supervision. When our next meeting rolled around, I carried my unease, anxiety, and fear into the supervision room. I remember a sense of dissociation as I reported to Dr. Bland everything that had happened with my patient. After I finished sharing, all my attention was fixed on his response. I remember having questions pace through my mind: How would he feel about this situation? Would he think that I threw him under the bus? Is he annoyed by me and my patient? Could there have been a way I handled this better? What would he have done? In retrospect, there were so many different self-states that I could have brought into the room. I could have expressed how scarred and shaken up I was from the experience of being the target of my patient's rage. I could have talked about how I was uncertain about his thoughts on the matter and requested to explore my uncertainty and confusion. Also, I could have expressed my initial thoughts on wanting to just write her the letter because it did not seem like a big deal to me. There were a variety of other thoughts that I could have shared, but I chose to report back to him in an apologetic and shameful manner that restricted my ability to be reflective and authentic.

My state of anxiety highlighted, and I did not believe that Dr. Bland would be able to tolerate the difference in our affect and thought. While I was unaware of my resistance in the moment with Dr. Bland, I was retrospectively able to recognize my disavowed self when I recalled guessing what would be on his mind, instead of staying curious and reflective of myself. After listening to my experience with Rachel, Dr. Bland asked what was on my mind and what I wanted to do. Interestingly, despite this invitation to be recognized, I deflected his question by sharing that I did not feel knowledgeable or competent enough to make the right decision and hoped that he would tell me what to do. The complementarity dyad continued until Dr. Bland invited us into a different realm of discussion. Instead of directly asking me for my thoughts, he reflected on his strong resistance to the patient. He expressed his surprise towards his atypical and uncharacteristic response to matters like this and that he had felt annoyed by the patient's entitlement. As he owned his own affective experience and countertransference to the situation, a process of self-reflective surrender, I began to see his reaction as a subjective reality, rather than

an objective and universal truth. While I was not fully aware of what was happening in the moment, I believe this process helped me begin to loosen my grip on his reality and begin to access my own mind regarding Rachel and her request. Towards the end of our supervision, Dr. Bland suggested that I should ultimately make the decision with my patient, and I walked out feeling like I was given an unbearable and impossible charge.

Throughout the week, I grappled with attuning to my own affect and thoughts on this matter. During the process, I felt stressed, overwhelmed, and burdened by the task of knowing and staying curious with myself. The more that I tried to engage, the more I felt confronted by a chorus of thoughts and reflections. For instance, I did not want to give into the pressure of my patient and reinforce the idea that her anger and rage would get her what she wants. I also did not want to make the decision simply based on Dr. Bland's judgment. I did not want to be the mediator either; this was not the thirdness I was seeking. There were numerous other thoughts that seemed valid and important, but, in the end, these thoughts felt reactionary. Instead, what felt authentic for me in the situation was that I did not mind writing the letter for my patient, and, while her approach was off-putting, I did not feel the same level of resistance that Dr. Bland felt towards her. It was challenging for me to rely on my authentic experience and selfhood to inform my decision, but I borrowed Dr. Bland's confidence that he displayed when he owned his countertransference. His self-reflective invitation created an opportunity for me to authentically reflect and struggle to find thirdness. Eventually, I let him know that I was willing to write the letter for my patient as long as there were specific parameters around this permission to ensure the safety of the patient and those in her apartment complex. Dr. Bland responded with full assurance and validation, and his response left me feeling empowered and respected.

As we were navigating this case, Dr. Bland and I were already in the process of writing about the third space. This experience with my patient propelled us to become more intentional about examining and articulating our experiences of thirdness and pushed us forward in our work. However, as I engaged with creating and articulating meaning out of the therapeutic and supervisory relationships, I was continuously confronted with my susceptibility to acquiesce and relinquish my knowing and my propensity to submit to the reality of the other. As I was writing my part of this paper, I often felt stunted and paralyzed to bring in my authentic voice, and I doubted what I knew about myself and the experience. I think the biggest challenge for me was having to confront my own uncertainty, doubt, and resistance to bring myself into the work, which is a necessary step in attaining a place of thirdness. I avoided sitting with my confusion and lack of confidence, and I kept pushing away the deadline, hoping that my thoughts would somehow be consolidated by the time it was due. As a student who had never missed a deadline, I found it uncharacteristic of me to continuously push back deadlines for this paper. However, these moments that appeared out of line with myself became a steppingstone to accessing my authentic self, just as it was modeled for me during supervision when Dr. Bland owned his own resistance to Rachel. Moreover, supervision has been a place where I was able to gather and find myself. The movement towards mutual recognition and freedom in supervision have been a source of relief and assurance. While it was hard to articulate the developmental processes of finding thirdness and many times I did not even recognize it in the moment, I think the sense in which I was able to own what I know and feel at peace with my thoughts has been the marker of entering the third space, both with Dr. Bland and Rachel.

I have been gradually recognizing the way Dr. Bland has been able to offer a holding space for me. As I shared my affective experiences of feeling stuck between him and my patient, or even when I shared my honest opinion about not feeling opposed to granting my patient's request, he was able to contain and suspend his own immediate need and stay curious with my experience. His willingness to stay connected and engaged with me in our differences allowed me to feel safe to be seen and more open to trusting that he is able to tolerate my thoughts. Our experience helped me understand that it is not our alikeness or our congruent affective experience that fosters genuine connection in the relationship, but it is the ability to mutually recognize the distinct selves in one another that allows us to find genuine connection and freedom in the relationship.

Earl's Experience and Finding Thirdness

It is noteworthy that my annoyance went largely unanalyzed when Christina and I initially discussed Rachel's minor request. Instead of reflecting with Christina, something I would normally do, I felt an immediate resistance, like I was being forced into doing something I did not necessarily want to do. Upon further consideration, I noticed feelings of disdain at what I was assuming was Rachel's presumptive entitlement. Partly, I think this was related to my experience of Christina's anxiety, and the way I felt she was being pushed around a bit by Rachel, but mostly it seemed related to my own subjective transference to Rachel's insistence. Partially reacting from my own allergy to experiences of being controlled (destroyed) by rules that seem arbitrary or patronizing, I lost empathy. To avoid my own whispers of shame, I reverted to a power move cloaked in professional legitimacy as I asserted that there was no precedent in the literature that I knew of to grant such a request. It was not an emotional support animal; surely, she could find another place close to her apartment complex where she could skateboard. Further, not only did I not examine this response, I also did not reflect how Christina might be feeling about my characterization of the situation. This is disturbing for me to admit; as a supervisor, I intentionally strive to develop a relational connection with my supervisees, where mutual consideration and input regarding clinical work and professional development are engaged with the maximum amount of freedom possible. Given that much of my supervision of doctoral students also includes an evaluative component, the struggle to recognize and hold the power differentials is difficult as I sometimes loose immediate awareness of my influence in the room as a seasoned expert. In addition, because I find supervisory experiences that reduce performance anxiety and shame to be most facilitative of developing a psychoanalytic sensibility, it is very common for me to invite conversations about what might be going on for the supervisee and myself in our understanding of the patient. In many cases, we explore how we are thinking and feeling about the patient in a way that fosters curiosity, connection, and useful treatment. Given these priorities, and the fact that Christina and I had been working together for almost two years, the complete collapse of this position in our initial discussion of the skateboard speaks to the oft precarious position thirdness and recognition hold in clinical dynamics. While there are many aspects of this situation that we could explore, I want to focus briefly on two entangled elements: the dynamics of power and parallel processes.

If we think about power dynamics as a relational construction, there are at least two aspects of this dynamic that are important to reflect upon. First are the social/contextual givens that take shape due to personal attributes and the purpose of our relationship: White, male, heterosexual, immigrant, and older professor/supervisor and Korean, female, heterosexual, immigrant, and

younger student/supervisee. However, these consciously available features, and the agreed upon functional dimensions of our relationship, do not necessarily lead to a consideration of normative unconscious processes that continuously exert influence (Layton, 2006). At this implicit level, the subtle shaping power of sexism, racism, classism, etc., continually threaten to derail our progress as we navigate the intricacies of the power dynamics inherent in our work. The second dimension worthy of scrutiny is the particularity of power as it is animated within the unique developmental trajectories Christina and I have experienced. It is not just that I am an older White male and she a younger Korean female; we each bring the unique situations that have stamped our personal developmental as distinctive expressions of the aforementioned givens.

The experience of parallel process, when the supervisor dyad begins to echo dynamics active in the clinical relationship, is not simply the repeating, or the supervisee acting out in a manner that recreates disavowed treatment dynamics. If all supervisory experience is co-constructed (Sarnat, 2019; Watkins, 2017), understanding the triadic nature of influence—both top down and bottom up—allows for greater clarification of the way projections, displacements, and disavowed affect states travel between patient, therapist, and supervisor. In response to the entanglements afforded by triadic enactments, I appreciate the words of Jon Mills (2004) when he stated, "It is incumbent upon the clinicians to embrace their own processes—no matter how sordid or unrefined—rather than repudiate them under the illusion of transcendence" (p. 468). I think this is especially true when power dynamics are at play in the supervisory dimension of the relationship, as unconscious elements have more elbow room to find expression and articulation under the guise of legitimized *expert judgement*.

Of the many cases I supervised, Rachel entered our conversations regularly as we talked about how Christina could best position herself to support her through some turbulent times as she struggled to find her own method of managing highly painful longings for affirmation and recognition. One of the things I failed to realize was the way in which Rachel's desire to skateboard was not an expression of rebellion or rule breaking, but an emancipatory effort to express her own idiom (Bollas, 1992); it was her own way of managing the devastating loneliness and self-loathing that would, at times, overtake her. I reject that Rachel's rage in this instance was evidence of a pathological organization; rather, to see her response as a reasonable comeback to the personal and structural diminishment of her own freedom of expression and the way I was "doing dominance" by proxy (Fors, 2018, p. 66). It might be important to state that Rachel had thoughtfully planned out a specific section of the common area that was somewhat isolated and not typically trafficked by the other residents. She was thinking about others, trying not to disrupt their living experience while seeking to express herself in a way that calmed and rejuvenated her. As I disavowed my own weakness, enacting the complementary dimension of a dominance/submission split, both Rachel and Christina were left to deal with the perpetuation of male dominance (Benjamin, 1988; Davies & Frawley, 1994). In addition, the manner of this dominance manifested normative processes of sexism and echoed the trope of White male privilege in deciding the appropriate movement and speech of female and Asian bodies.

As Fors (2018) pointed out, when privilege favors the therapist—and, by extension, the supervisor—it is critical that this power be held in a manner that is sensitive to temptations to disavow weakness, self-license legitimacy through benevolent acts (sometimes called *virtue signaling*), or to default to a position of normative neutrality. It is particularly troubling that one

of the legitimizations I used in my initial refusal to affirm Rachel's request, or to explore Christina's thoughts on the matter, was to cite the lack of empirical support for her request. Not only is this not my typical style, but it demonstrates the hegemonic masculinity typical of detached objectivity and the diminishment of personal contextualized experience. Through this supposed unemotional empirical frame, I could feign a level of impartiality and gain distance from the echo of my historical experiences of shame as I, too, struggled for self-expression as a teenager and young adult against the powerful forces of parents and religious leaders. The flow of desire for recognition traveled its way through the inherent power differentials in the structure of patient, therapist, and supervisor. As each of us struggled for recognition, the elusive third space did not present itself until I took responsibility for my own havoc of dominance and Christina voiced her perspective.