Response to Francoise Davoine’s “The Character of Madness in the Talking Cure”
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“Who are these? Why sit here in twilight?...
These are men whose minds the dead have ravished.
(Mental Cases, Wifred Owen)

It is current practice in the psychiatric field for authors to make a declaration of interest, i.e., to announce one’s ties to any outside agency, such as a pharmaceutical company, in order for the reader to determine any potential bias. I feel compelled to make not a declaration of interest but a confession of non-neutrality. I know Dr. Francoise Davoine for many years now and I must say I remain enchanted. I am enchanted by her depth of intellect, courage and compassion. This also applies to her colleague-husband, Jean-Max Gaudilliere (Davoine & Gaudilliere, 2004). I count myself fortunate to be considered a friend and colleague. Through my association with them, I have given much more attention to the interaction of the individual’s ‘little history,’ including the family history, with the ‘big history’ of the wider sociocultural context, including social catastrophes, upheavals and disasters across the generations.

Silver, Koehler and Karon (2004) proposed: “It is only in the uniqueness of the history of each individual, and in the meanings that each person assigns to that history and to their ‘symptoms,’ that any true cause [of mental illness] can be discovered” (p.209). After reading this ‘case’ study of Francoise Davoine, and while making an attempt to write something that psychotherapists and psychoanalysts might find worthwhile, as I gazed out of my window looking out over the beautiful English countryside on a lovely summer day, I found my mind driftiing to the following vision: Francoise and her patient were walking hand and hand across the misty, haunted moors each with one eye bandaged so that they had to rely on the other’s vision to gain perception of depth. It was this interdependency and interpenetration of ‘visual’ and psychic fields which allowed the patient to symbolically repair and set free the ghost of her mother, in effect her absence, which had been haunting her for years. Francoise sees madness as a struggle with undead ghosts arising from personal as well as wider social catastrophes. The restless and hungry ghosts of the Real cry out for a proper burial in which their names can become inscribed into the symbolic order. According to my Finnish colleague Martti Siirala (personal communication), for this transfer of burden, arising from past murders and catastrophes, to emerge in the transference, the therapist must faithfully occupy a very uncomfortable place. Martti Siirala defines this kind of therapy as:

“Therapy ensues when, the following takes place, what in itself is the very natural and yet represents an exception among us? I mean the appeal and message inherent in each human predicament, also met as illness, exceptionally reaches an ear-with the result that the other accepts to listen to it together with the inflicted and remains faithful in that dialogical place, prepared to share it with the other”(these ideas are further explored in Siirala, 1983).
For Francoise Davoine, as for Erasmus, madness reflects on a rupture and weakness in the social link. The mad subject needs the other as witness in order to move beyond madness. This reminds me of Herbert Rosenfeld’s (1987) point about projective identification and countertransference: the patient’s forceful projections if interpreted by the analyst as an attack is a technical error, since it may be that the patient suffered traumas in isolation and needs someone to be, in the words of Leon Grinberg (1997), consubstantial with them, i.e., to share in the experience. Francoise speaks of the transformation of the analyst from innocent bystander to cruel persecutor. As Harold Searles (1979) and Grinberg (1997) noted, this is a positive step in the development of a psychoanalytic process which could potentially lead to curative action. The uncanny double, invoked by the patient during psychotherapeutic treatment, reminds me of Melanie’s Klein’s (Grinberg, 1997) concept of the internal object, which ‘resides’ in the deepest tissues of unconscious functioning, as well as gets projected into various significant external figures, of course, including the analyst. Francoise understands these mad figures to be emerging from the Lacanian Real, i.e., that which has been impossible to inscribe/symbolize in language. Shamans and medicine men might understand these powerful and terrifying introjects as demonic forces which need to be tamed and killed through one’s ingestion and therapeutic metabolism of them (similar somewhat to Bion’s model of contained/container).

Francoise’ invokes fellow travelers through this territory of undead ghosts, or dying, damaged internal objects in the language of PostKleinian Henri Rey (1994), including Ludwig Wittgenstein and Artaud, in particular, the former’s theory of the tool of names being broken, and the latter’s ideas about a split between words and things. She also uses the metaphor of No theatre in which the current drama is linked to the world of the dead by a bridge. The unfolding drama takes place between the Waki, the therapist, and the Shite, the patient, in which a story of betrayal, violent acts and lies are told. An uncanny encounter takes place in which the Waki enters the dream world while the Shite links up with the world of the undead dead in order to tell the full story of past murders and crimes. This realm of past catastrophes and murders is contained in Finnish psychiatrist-psychoanalyst Martti Siirala’s (1998) theory of the “transfer of burden.”

In his paper “Psychoanalysis and social pathology,” Siirala (1998), writes:

“The discovery and developing of psychoanalysis by one single person, Sigmund Freud signifies a breakthrough in the wall which had come to separate us from the message carried by each [person’s] illness. Listening faithfully to that message gradually led to a process of sharing, through a dialogue with the inflicted person, the human predicament about which the illness mediates an appeal.”

When “dead-end” existential solutions find no kind of responsible encounter and sharing, they become, Siirala suggests:
“...transferred as a burden, both horizontally in the micro-and macrosocieties involved and vertically from one generation to another. Its destructive effects in both dimensions become ever worse and ever more anonymous. On their wandering they may...result in mental or bodily disease.”

Siirala believes that if this situation is met by psychotherapy “...one of responsible dialogical and faithful sharing-eventually demanding many years of mutual presence, the vicarious burden may yield its human treasure.”

Francoise now presents her patient further to us. She is a pale young woman with a frozen face, newly having escaped from the psychiatric hospital. Francoise invites her patient to link up with and speak of this land of the ghosts, of the undead dead, like the Waki of No theatre. The details of the events surrounding her multiple hospitalizations are given, and Francoise responds, out of the welter of the patient’s disorganized narrative, “it is your resistance that is driving you insane.” Indeed, resistance was a signifier which ran like a thread through the incoherent narrative. Francoise’ countertransference reaction to having used the word “insane” towards this confused and confusing Shite, was one of regret. Again, as the patient is leaving the analyst’s room, Francoise utters another surprising (to herself) comment in response to the patient’s anxieties about her children’s future: “I immediately replied that one day she would be able to recount the whole story to them.”

The patient, somewhat surprisingly for Francoise, returns for her second session. She appears much better and seems to have reengaged with the world of others. This woman commences to speak of the traumatic loss of her own mother during the time of Nazi occupation of her country. Her mother, working for the French Resistance, is arrested by the Nazis and is never to be seen by our Shite again. She says that she goes to hospital in search of her mother among the living dead. Perhaps, this is an illustration of the patient’s solipsistic attempts at restoring and repairing her mother. Francoise’ patient continued to relate her story through memories, dreams and associations. This young woman saw her mother being arrested at the age of two years, thereby breaking the tool of names and rupturing the attachment bond (Carter et al 2005).

Soon after these internal/external events, Francoise recognizes the foreclosed reality of the patient turning up in herself in the form of a vivid dream:

“I could see my son who was then a baby lying drowned in the basin of a fountain that was inside a house. I can still remember the horror that this vision inspired in me. I take him in my arms to give him mouth-to-mouth resuscitation and I see the colour and life coming back into his cheeks,
As in No theatre, this dream of Francoise’ is a bridge to the world of the ghosts. Francoise interprets the baby as the “double” which was going to make the dyad relive a period of breakdown between “words and things.” It is this dream image of the fountain basin inside a house that brings Francoise closer to her own story. Self-analysis leads Francoise to understanding this image as her being inside her own mother’s womb arising from a counteridentification (Benedetti, 1987; Koehler, 2003) with her therapeutic partner. In this dream, Francoise and her patient become one in the midst of such a terrible rent in the social fabric. They share a similar experience of the “dead mother” (Green, 1993), Francoise’ loss occurring on a psychological level, and her patient’s loss occurring on a more concrete level. The baby in the dream is the “double” which enables Francoise to transcend the “usual limits” of their clinical exchanges. From my perspective, this would be understood as an active counteridentification which reflects on the developing nonverbal therapeutic symbiosis (Searles, 1979; Benedetti, 1987). In the language of Gaetano Benedetti, (Koehler, 2003) this baby is a transitional subject composed of dissociated elements of both of the therapeutic partners. In Benedetti’s own words:

“My transitional subject is a dissociated self, a part of the self which needs the cradle of the presence of the therapist in order to become his whole self. It is a part of the self of the patient which becomes the total self as a transitional subject which includes the figure of the therapist” (p.79).

I understand this dream of Francoise’ to possibly signify a double identification with her own mother and her son/daughter patient. The successful “mouth-to-mouth resuscitation” reflects on Francoise’ infusion of her life into her damaged, lifeless analytic child. Strangely, after this therapeutic dream, the analysis becomes deadened, more lifeless, as if the patient was defending against the growing emotional closeness. Attachment theorists might suggest that the closeness signified the threat of abandonment for this person. Searles might suggest that both, patient and analyst, defend against the developing therapeutic symbiosis. From a PostKleinian perspective, one might view this an attack on linking (Bion), or as an attack on dependent, libidinal relatedness by an omnipotent, narcissistic self (Rosenfeld, 1987). Sullivan might view this as evidence of malevolent transformation, and Freudsians might see this as a negative therapeutic reaction arising out of separation guilt or anxiety, or a ‘good hour’ (Kris, 1975) needing to be followed by a ‘bad hour’ (Daniel Schwartz, personal communication) in order for the patient to reestablish permeable ego boundaries.

Francoise invokes the words and ideas of Artaud to serve as a compass through this impasse. A void develops which acts as a prelude to the arrival on the scene of the character of madness, like the character of Breughel’s Mad Margot. The latter is a towering militant-looking figure who forces the living into the hell of meaninglessness and namelessness. At this time,
Francoise’ patient tells her that at each hospitalization, she felt possessed by an evil spirit. This reminds me of one of my patients, who at the end of our sessions would feel that he became Satan, the monstrous separated one. An evil spirit would materialize in the wake of experienced rejection, loneliness and isolation. Francoise notes the necessity of enactment before a deeper understanding can unfold between the therapeutic partners. She believes that the enactment can eventually lead to inscription into the symbolic order.

At this point in the analysis, a crucial moment occurs which does not directly involve the patient. The latter’s psychopharmacologist contacts Francoise and tells her of his disregard for the type of work she is engaged in with the patient. Francoise tells us that she feels intimidated. Rather than defensively responding in some way, she simply asks permission for her patient to be allowed to attend her sessions. The psychiatrist politely agrees. Again, Francoise comes up against a typical countertransference experience when one works with more disturbed patients. A strong ambivalence and wish to have never entered such turbulent territory—what Gaetano Benedetti has called the “deathlandscapes of the soul.” The patient is the cruelly treated mother and terrified, rageful and abandoned child. The transference/countertransference interaction reminds Francoise of Artaud’s definition of his theatre of cruelty—a situation which stands to be annihilated at any moment. The patient cruelly curses Francoise. Francoise stands in the place of the murdered, dead mother and the mother she never had as a child. In the language of PostKleinian psychoanalysis (Rosenfeld, 1987), the underlying persecutory omnipotent object relation has surfaced (a sign of psychotherapeutic progress) overriding any previous idealizing transferences. Francoise, at first, owns the projections of the psychotic transference, she feels responsible, the blameworthy one. In the language of Harold Searles (1979), the analyst is in the phase of the psychotherapy in which she feels responsible for the symptoms afflicting the patient. Searles notes: “These are instances in which the analyst is reproached, whether explicitly or implicitly, as being to blame for the patient’s symptoms, and in which the analyst experiences anxiety, guilt, and remorse in this regard” (p.513). In speaking of this phase in the patient-therapist interaction, Searles (1965) concluded:

“At its fullest intensity, this phase is experienced by him [the therapist] as a threat to his whole psychological existence. He becomes deeply troubled lest this relationship is finally bringing to light a basically and ineradicably malignant orientation towards his fellow human being. He feels equivalent to the illness which is afflicting the patient; he is unable to distinguish between that illness and himself. This is not sheer imagination on his part, for the patient is meanwhile persistently expressing, in manifold ways, a conviction that the therapist constitutes, indeed, the affliction which threatens to destroy him and to which he, the patient, is locked in a life-and-death struggle. In my theoretical view, the therapist is now experiencing the fullest intensity of the patients’ transference to him as the Bad Mother” (p.533).

For Searles, these symptoms, which not only develop sadomasochistic object transference meanings, also come to represent the bond of a mutual deeper dependency between patient and
analyst. Searles believed that for a more individuated identity to be formed out of the crucible of the analytic dyad, the patients’ symptoms must not only become transitional phenomena for the patient herself, but for the analyst as well. I believe that Searles (personal communication) felt that this was one of his primary contributions to a theory of therapeutic action in psychoanalysis. Each symptom, from a PostKleinian and Searlesian perspective, is relationally constituted, i.e., is referable to some pathogenic introject or constellation of such introjects, unmetabolized unconscious relational configurations derived from early relational and social experience.

It is at this moment in the analytic process, that Francoise interprets what she senses is actually transpiring between her and the patient in the here and now of the relationship. She tells her patient:

“I think I told her I had no doubt been drawn at her request into an adventure that was not without danger but that I was there, disguised with these carnival masks of Hitler and Mengele so that she, or rather her mother through her, could emerge from her unsullied role of the heroine, and express her hatred at having been betrayed” (page number?). This interaction and interpretation by Francoise proved to be a turning point; madness disappeared from the stage. The patient seemed her former not-mad self. The patient reveals her rage at her mother for ‘abandoning’ her. As Klein (1992) suggested, an absent object can become a persecutory one. This persecutory mad figure materialized, came out of hiding, in the crucible of the analytic relationship. This emergence of what Bion has called a moment of catastrophic change (Grinberg, 1997) enabled the patient to face the real external enemy—a former Nazi on trial—and to symbolically put her mother’s ghost to rest in herself by accessing the convoy list of doomed individuals where her mother’s name was to be actually found.

Henri Rey (1994) suggested, in accordance with Melanie Klein (1993), that there is a layer of the mind in which representations are experienced as concrete and real objects, such as dream objects. Rey believes that while the patient may be asking for help in regard to improving oneself, the real request may be to help repair one’s threatened and dying internal objects, a reparation without which the subject’s self cannot function well in the world. Rey’s thoughts on this dynamic process are evident in the following passages:

“In the course of my work over the years I have become aware, especially with very ill patients, borderline and psychotic, but not exclusively so, that their internal objects were seldom if ever dead, but rather were kept dying and not dead by the patients. But it was only very slowly that one important reason for doing so became clearer to me, and this was that so long as the objects were kept alive there was a chance to repair them...and, so long as they were kept alive, there was hope that somebody would come who would know how, and would help to do it” (p.245)

Melanie Klein (1992) commented on the dread of harboring dying/damaged or bad objects
inside and the threat of identification with them.

Francoise’ Dream

Psychoanalysts have recently made valuable contributions to the understanding and use of dreams within the psychoanalytic setting (Lippmann, 2000; Blechner, 2001). Lippmann (2000), in consideration of the role of dream interpretation in psychoanalysis, noted:

“Dreams and therapy go together. There is no better way to the soul’s secrets. In psychological pain, the soul’s secrets are still the ones that count. And in the relative freedom of dreaming and dream-listening, it is still possible, despite the ‘death of psychoanalysis,’ to talk together—with dreams at the center—toward self-understanding and the relief of psychological suffering” (p.245).

Blechner (2001) views dreams as a frontier experience, in which the dreamer is released (I would say partially, not completely) from the constraints of social experience. He suggested:

“Dreams are themselves a frontier. They are the frontier of human knowledge, imagination and creativity. They are the breeding ground of the truly new. In dreams we pull together all that we know and all that we have experienced, and then we create new experiences” (p.3).

Did Francoise tell the dream to her patient? Although there are many countertransference issues and risks to the treatment surrounding this, some psychoanalysts have made clinical use of their countertransference dreams, e.g., Gaetano Benedetti (1987). Blechner reveals that he has, on occasion, told some long-term patients dreams he has had of them. He believes these dreams, and the telling of them, may sometimes be in the service of resolving treatment impasse. This has been my experience

Jung used dreams quite often in his work at the Burghölzli Psychiatric Clinic with psychotic patients. Sullivan related psychotic referential processes to nightmares. Ernest Hartmann (1998) related both nightmares and schizophrenia to ‘thin’ permeable boundaries. Personally, I believe that one of the functions of dreaming is to maintain and negotiate relational attachments during sleep. Nightmares signify the threat of annihilation of the self secondary to object ties being severed. More frequent REM sleep in infancy, perhaps, could also be in the service of not losing the attachment to the necessary caregiver. The shared nature of unconscious traumatic experience emerging in the analytic dyad, e.g., the dream of Francoise, speaks to the relational nature of the analytic enterprise.

Blechner (2001), in regard to the telling of one’s countertransferential dreams, noted:
“If you are going to tell a patient one of your dreams, you must also accept the fact that you will be telling your patient much more than you realize...Telling a patient a dream implies a very high degree of self-revelation, whether or not the analyst intends it. And so, if you tell your dreams, you must be willing to collaborate openly and sincerely with the patient in interpreting your dream” (p.225).

Rey (1994) emphasized the role of dreams in reparative processes. Resonant with the dream of Francoise,’ Rey remarked about his patients dreams:

“The dreams were of very damaged parents. Most striking was how the deadened parts of him and of his objects were brought to life with the intention of using my help to repair them. He [the patient] had not known how to do this alone, and seemed, in the words of a patient of Melanie Klein, to have kept them in a state of suspended animations...What he could not repair alone and had kept alive and hidden was reappearing in the treatment” (p.241).

Melanie Klein (1992), in her paper “A contribution to the psychogenesis of manic-depressive states,” proposed:

“...the ego feels itself constantly menaced in its possession of internalized good objects. It is full of anxiety lest such objects should die. Both in children and adults suffering from depression, I have discovered the dread of harbouring dying or bad objects (especially the parents) inside one and an identification of the ego with objects in this condition” (p.266).

Relational Aspects of Madness

Madness, according to Francoise, involves a crisis in the social link, and is an attempt to research and reveal past wrongs which were not inscribed in the social order. Therefore madness is a collective affair. This resonates with the viewpoint of Finnish psychiatrist-psychoanalyst Martti Siirala (1983):

“This implies that a manifest schizophrenia is part of a common darkness, not only the darkness of an individual or a family. Traditionally we tend to conceive of schizophrenia as a disturbance in the normal life process: a disturbance in an individual’s existence, brain, mind or metabolism, in interpersonal relationships, in family dynamics...Schizophrenia is presented here more as a general human situation, one that centers around a manifestly split individual but emerges out of a common soil of sickness: a sickness shared by the others, the healthy” (p.19).

Francoise ends her story with a reference to a tribal child whose vision only becomes real within the social context of an elder’s dream. I am reminded of the well known aphorism of Martin Buber: “All real living is meeting.”Francoise and her patient’s story involves a mutuality of impact and change, of unconscious dyadic and sociocultural resonance, of intersubjectivity. Perhaps we might understand this aspect of analytic treatment from the perspective of relational/interpersonal
neurobiology/psychobiology. I like to think of my own research in the field of mental illness (besides the clinical research involved in my private practice) as relational neurobiology/interpersonal psychobiology (which includes epigenetic processes & neuroplasticity). We are continuously learning about the impact relational and social experience has on the developing person, including the CNS. There is research demonstrating in mammals that fetal cells could transform into neurons, astrocytes, oligodendrocytes, and macrophages-crossing the maternal blood brain barrier and responding to molecular distress signals if the mother's brain is injured. The mother's brain regulates to a significant degree, e.g., through the maternal-placental-fetal neuroendocrine system, the developing fetal brain, creating long-term predispositions towards stress reactivity (e.g., placental corticotropin releasing hormone/factor). Social pain, e.g., social exclusion, is equivalent neurobiologically, i.e., activation of the dorsal anterior cingulate cortex (dACC), to actual physical pain-words and social isolation are painful. Social status in mammals, e.g., the sense of being dominant or submissive, influences the actual structure (volume changes) of certain neural regions, e.g., the hippocampus. Mirror neuron systems help us to replicate within our own brains and minds the experience of the other.

In quantum physics, experimental research on “entanglement,” points to the interconnectedness of what classical physicists call matter. Cloninger (2004), Professor of Psychiatry and Genetics at Washington University School of Medicine, notes:

“The experience of nonlocality leads to increasing depth of recognition of phenomena that are unique to quantum physics, such as noncausality and nonlocality. Nonlocality refers to the inseparability of the bits of information. It is the beginning of the recognition that information may be the fundamental basis of reality. Localized particles of matter cannot be the fundamental basis of reality, as shown by rigorous demonstrations of action at a distance. When there is nonlocal causality or action at a distance, a causal influence on one ‘object,’ has an instantaneous influence on another remote but ‘entangled object.’ Noncausality and nonlocality are the properties that distinguish quantum physics from classic and relativistic models of local physical realism” (p.195).

Perhaps, the universal experience of loneliness (Klein, 1993b), which as Harry Stack Sullivan pointed out could be extremely painful as have many psychobiologically oriented researchers, is the other side of the relational coin. Hans Trüb, a psychotherapist influenced greatly by Martin Buber, realized that the abyss in the patient calls to the abyss, the real, unprotected self, in the psychotherapist, and not to her/his confidently functioning security of action. I think we see this in Francoise and her therapeutic partner.

I would like to end this with the profound words of Martin Buber (Will, 1987) and Bakhtin (Pines, 1998), respectively:

“A soul is never sick alone, but always through a betweenness, a
situation between it and another existing being. The psychotherapist who has passed through the crisis may now dare to touch on this” (p.291).

"I am conscious of myself and become myself only by revealing myself to another, through another and with the help of another...Every internal experience ends up on the boundary. The very being of [woman] man (both internal and external) is a profound communication. To be means to communicate...to be means to be for the other; and through him [her] for oneself. Man has no internal sovereign territory: he [she] is all and always on the boundary" (p.55).

References


