the work we've done, to put it down. It's hard to see
now how the lake can be filled again.


):4:3 P: Right. It was different when I went off to college. I
was glad to be getting away, and my parents were glad
to have me go so they could get on with the day's
chores. Here I feel love and affection, and that in a
way you are my best friend—and you are. Now it's
time to transfer all of that to other relationships that
aren't so circumscribed. I'm picturing leaving home on
the bus with the door closing behind me.

):4:4 A: What are you finding?

):4:5 P: The hardest thing with you is to get clear and to stay
clear, that you don't feel martyred to have me here or
are anxious to have me go so you can do something
else. That you do get pleasure from my accomplish-
ments, and have empathy for my sadness, that you feel
proud of my accomplishments.

):4:6 A: That I feel proud of your accomplishments as you have
accomplished them.

):4:7 P: What do you mean [slightly alarmed]?


[I am emphasizing her justifiable pride in her actual accom-
plishments rather than her embellishments in fantasy by
dazzling performances or saintliness and moral superiority.]

):4:9 P: [nods] What am I proud of? Proud that you don't want
to kick me out so someone else can take my place.
Proud that I am being considered for two fine jobs.
Proud of my uniqueness that makes it possible.

Lichtenberg, Lachmann
& Fosshage

The Clinical Exchange

4 Ten Principles of Technique

The topic of technique is tricky. Technique includes procedural rules,
but procedural rules can become authoritarian restrictions. Technique
includes conceptual principles, but conceptual principles can become
arid pedantry. Technique can be taught didactically, but "didactic"
can become lifeless and academic. The task for the clinician is to
maintain one foot on solid, empirical ground and the other foot on
the fertile soil of creativity, being careful that neither foot ends up
in the clinician's mouth.

To the experienced clinician, technique is second nature, informed
by experience and knowledge. Yet, discussions of technique are in
danger of formalizing creativity and subverting the very spontaneity
that is intrinsic to good treatment. Discussions of technique, rather
than enlarging the clinician's perspective, can interfere with estab-
lished, reasonably successful ways of working. The experienced clinician
will recognize in our user-friendly, self-psychological technique both
an attempt to codify what may already be familiar and congenial,
and an attempt to legitimize what is often done, but not discussed
openly in seminars on technique.

To the beginning clinician, technique is the sought-for answer to
the questions what to do, and when and how to do it. Learning
 technique provides guidance and may decrease uncertainty. Nevertheless,
technique as a formula can be misapplied and thus interfere with
the inevitable uncertainty with which even the most experienced
therapist must live (Moraitis, 1988; Franklin, 1990; Friedman, 1995).

In that case, technique can mechanize the therapeutic encounter
and undermine the spontaneity we hope to promote.

A number of years ago, one of us (Lachmann) taught a con-
tinuous case seminar in which the sessions of an analysis he was conducting
were presented to the class. The patient told a dream in which she
was playing tennis. After a few comments about her tennis partners
and opponents, the patient fell silent. The analyst waited awhile and
said to her, "It's your serve." The patient then began to talk about
her difficulty in taking the initiative. The class thought the inter-
vention was clever. One of the students in the class was in supervision
with the teacher-analyst. Lo and behold, when her patient fell silent
during a session, she said to him, "It's your serve." Although the
udent’s intervention did not quite fit because there had been no
erence to tennis during the session, it was not far off. In fact,
t a patient did begin to speak. However, Lachmann’s point had
ten to illustrate the use of imagery and metaphor as jointly constructed
analyzer and patient. The material was not presented to teach a
tchnique for enabling therapists to overcome silences. Although
student’s misunderstanding did not damage her or her patient,
ether did what she said promote creativity in technique. Taken
of a specific context, an “improvisation” can become a “ritual-
ed script.”

Therapeutic action is furthered by a mutually constructed creative
ommunication in which an analyst “gets” a sharper insight into a
atient’s experience, and conveys this insight to the patient in a
ique manner that enables the patient to feel “heard” or “under-
ood.” At their best, analyst and patient constructing an experience
uld not have occurred between this analyst and any other
ent. No matter how familiar an interaction may look to the
ayst, how “right out of the textbook” it may feel, only the unique-
ess of analyst and patient’s mutually created, shared experience can
id to heightened, affective moments (Pine, 1981; Beebe and Lachmann,
94) that become transformative.

It is easier to formulate analytic technique than it is to teach
alytic creativity, spontaneity, or intuition. With these caveats in
nd, we list and illustrate “principles” in the art of psychotherapy
d psychoanalysis. We will use clinical material from the treatment
Nancy to illustrate these principles.

We have originated some of the principles that follow; others we
ave borrowed and modified. The specificity with which we have
en able to describe the ten techniques derives from our applica-
on of them in our own therapeutic endeavors—and especially in
aching and supervising others. They have come to the foreground
our thinking against the background of our theories of self psychology,
nt studies, motivational systems, and of self and mutual regul-
ations.

THE TEN PRINCIPLES

1. Arrangements that Establish a Frame of Friendliness and
Ability and an Ambience of Safety

Psychotherapy and psychoanalysis are best conducted in an ambi-
ice of safety for both patient and therapist. In the analyst’s manner,
and in the formal arrangement of the treatment, a frame of friend-
liness, consistency, and reliability is established. Our accent on these
“human” aspects of the therapeutic encounter can be contrasted with
those techniques that accent the role of frustration in analysis. However,
we do not suggest that an analyst gratify a patient’s requests, wishes,
or idiosyncratic expectations without question. Rather, we suggest
that the analyst respond affirmatively to whatever will help to estab-
lish a frame or set of boundaries within which both analyst and
patient can participate effectively. We do not propose that an analyst
set out to provide a patient with a specific beneficial experience that
may have been missed in the course of development. We do believe,
however, that understanding what the patient needs and wishes to
have provided constitutes a therapeutically necessary and legitimate
form of provision and gratification. We agree with Blatt and Behrends
(1987) that the “use (or misuse to be more precise) of the relation-
ship to create compensatory experiences must be distinguished from
a process in which the analyst allows the analysis to construct the
relationship in ways which temporarily meet infantile needs in order
to be able to interpret the constructions to the patient” (p. 282).

We illustrate the establishment of an ambience of safety by describing
two crises from the beginning of Nancy’s treatment, which occurred
prior to the first week of the sessions reported in Chapter 3. The
arrangements for the analysis had been consolidated. Hours had been
scheduled that took into account Nancy’s school and work commit-
ments. She used the couch without discomfort.

The first crisis was prompted by the analyst’s practice of ending
sessions by saying, “Our time is up, now.” On one occasion, Nancy
was having a difficult hour, crying bitterly as the end of the session
neared. The analyst stated his ending phrase in a sympathetic tone
with a prolonged “now.” Nancy said, “Don’t give me that patron-
izing ‘now’!” The startled analyst said “Okay” and Nancy left. During
the following session she described her resentment at being patron-
ized “when being thrown out.” She believed the tone of sympathy
was not for her benefit but to ease the analyst’s conscience, a belief
the analyst accepted. He resolved not to end the session in his usual
manner. But he was unsure of an alternative that would retain a
frame of friendliness and safety. He asked Nancy how she would like
him to announce the ending. She answered that he should just convey
the message directly and flatly, and say “the time is up,” because
that is what he meant. The analyst did so without incident but also
became sensitive to any inclination to shift his tone from appro-
priate concern to placating condescension or patronization. In addition
was ready to bring these issues to the forefront of the work whenever they appeared.

The second crisis concerned the analyst's fee. Nancy was paying somewhat reduced fee and talked a great deal about her money worries. She hated the arrangements in the laboratory in which she worked. Increasingly, she found the conditions dangerous, as errors in testing and reporting were common. She announced that she had leave her job for her self-respect and safety. She pleaded for a further reduction in her fee, as well as for the option to delay payment of her bill until some undetermined later date, as she had arranged with her previous therapist. Otherwise, she stated with increasingly hysterical emphasis, she would have to stop her analysis.

After a brief reflection, the analyst refused her demand. Although he was uncertain of all the facts, he doubted the practical necessity of the reduction that she claimed she needed. Additionally, he recognized the serious possibility that she might bolt because of his refusal. The main reason for refusing was that he did not want to offer his professional services at a further reduced fee or under the arrangements she proposed. He recognized that the frame of the treatment might not now feel friendly or reliable, or contain the ambience that was required, and he believed, that they were both required, for therapeutic success. Within a relatively short time, Nancy arranged for more satisfactory and better paying work, and she began to regard her problem in regulating her finances as an integral part of the analysis.

Establishing an ambience of friendliness, consistency, reliability, and safety is not confined to the opening phase of treatment. Analysts must pay constant attention to issues of our manner of approach throughout the analysis. The ambience of friendliness and liability is often placed in jeopardy by the manner in which the analyst handles a patient's need or desire for information. Despite one's (1961) objections, in discussions of analytic technique, responding to a patient's questions continues to be equated with providing gratifications that may interfere with the motivation to analyze.

In our view, responding to a patient's questions can promote the analytic exploration of the very issue raised by the patient. For example, when Nancy asked (83:1:3), "How can you do this all day, listen to this?" the analyst did not silently abstain, but responded (83:1:4-6) [Pause] does it put me at risk for getting out of control? [pause] I get stirred up as a result of what you're talking about." In s response, the analyst did not counter with "What makes you wonder about my ability to listen to you?" or "What makes you wonder how I can do this all day?" or "How do you imagine I can do this all day?" We recognize that parrying a question with a paraphrased restatement is a perfectly reasonable intervention designed to elicit unconscious fantasies. However, we have found that such standard analytic responses often disrupt the openness of the interaction rather than carry the exploration forward. They heavy-handedly throw the spotlight on the patient, gratuitously reminding him or her that he or she is the patient in analysis; that the analyst makes rules about a one-way informational flow and the patient must comply. They imply that what the patient attributes to the analyst is all based on the patient's fantasy, his or her curiosity as a source of shame, and that it is up to the patient to account for raising such a question.

None of these standard restatements conveys the extent of the analyst's continuous immersion in the patient's subjective experience. Specifically, at this point in Nancy's analysis, restatements by the analyst would not have conveyed his awareness of the sexual material that had just been offered. Thus, the analyst articulated his understanding of the relevance of Nancy's sexual references ("getting out of control") by connecting them to Nancy's question. By retaining the continuity of the content and of the transference attributions, he reinforced Nancy's ability to articulate her sexual fantasies. In addition, the standard restatement interventions carry the danger of increasing the patient's self-consciousness rather than increasing her sense of safety. To address this danger, we offer the second principle.

2. Systematic Application of the Empathic Mode of Perception

Our method of conducting treatment is based on the systematic application of the empathic mode of perception, whereby the analyst gains information to orient himself or herself by listening from within the perspective, the state of mind, of the patient. For example (85:1:7), the analyst's listening is guided by his sensing that Nancy's state of mind indicated she was delicately balanced between remaining in an affect-rich contact that would promote joint exploration and developing an aversive affect state that would disrupt cognition and preclude joint exploration. He deviated from a free-floating attentiveness to keep Nancy from plunging into an aversive affect state. That is, he risked an approach that she might experience either as positive and helpful or as humiliating and patronizing. The analyst also became somewhat puzzled over Nancy's reference to their "puzzlement" talk as "decadent." He was guided by a conviction that particular designators may serve as metaphors with ties to significant unconscious beliefs. Alternatively, to concentrate on his own "puzzlement"
Ten Principles

3. We Discern a Patient’s Specific Affect to Appreciate His or Her Experience; We Discern the Affect Experience Being Sought to Appreciate the Patient’s Motivation

as he or she would recognize it. Recognizing a patient’s discrete affects, moods, and affect states (see Chapter 5) is crucial to discerning, from the patient’s own perspective, the experience the patient is describing and currently having. Recognizing affects is not a cognitive activity, although cognition is involved, but is primarily the result of attuned resonance, of feeling along vicariously. To know that an event triggered affection, or indifference, or fear, or anger, or shame, or pride, or awe, or calm is a prerequisite for the analyst to appreciate the experiential meaning, the salience of the event for the patient. For the analyst to understand the patient’s motivation requires another step: to discern what the patient’s associations and actions reveal to be the affective goal (the selfobject experience) the patient seeks. We investigate whether the patient seeks a specific experience—such as the relief of a physical dysregulation, the pleasure of intimacy, a sense of efficacy and competence, sensual enjoyment or sexual excitement, or the reassurance or removal of an aversive state. At a more general level, we explore whether the patient seeks an experience of vitalization in response to feelings of depletion or a soothing experience in response to feelings of being overwhelmed with an intense emotional state.

Frequently the patient’s motivation can be inferred relatively easily. Nancy’s desire for the attention of the priest and the analyst on the weekend (83:1:1) was for the experience of a sense of closeness and the affirmation of her importance to people she admires (an attachment motivation). In contrast (87:1), the motivation behind the feeling of paralysis with which she had ended the session prior to this hour was inexplicable at the time. Then, when the analyst brought it back into focus (87:1:9), she indicated her motivation in saying, “the paralysis was to avoid drawing the conclusion it’s not a friend who does this stuff” and thus preserving the illusion of a positive attachment experience to her aunt and to Jane. On other occasions, the analyst may incorrectly infer a motive, such as the analyst’s presumption (83:1:8–9) that Nancy’s desire to know how he dealt with his sexual arousal served to enable her to use him as a mentor or model and achieve preservation of her sense of self-cohesion in that way.

Our third principle of technique takes into account the relative difficulty for analyst and analyses of exploring the analysand’s experience and motivation, and offers the analyst a guide for sequencing his goals in comprehension. Often the analyst must glean the affect as a first step. Only slowly then can knowledge of an event or exchange being talked about be built up.

For example, at the beginning of session 87.1 Nancy spoke about her chronic constipation, depression, and sense of moral failure. She
Chapter 4

Ten Principles

4. The Message Contains the Message

Any particular statement and the context of what preceded it and what follows it. As delivered by the patient, the message is a complex amalgam of shadings and nuances: gestural, vocal, and facial displays; transitions into and out of topics; emphasizes as to what is deemed foreground and what provides background, and “hints” that subtly illuminate the communication. All of these manifest aspects of the “message” can be surmised, inferred, and evaluated only from the delivered message. If fully appreciated, they can be as revealing as a baby’s face when compared to poor Yorick’s skull.

The proposal, “the message contains the message,” is often misconstrued as downgrading the role of unconscious motivation. In line with our description of unconscious mentation (Self and Motivational Systems, Chapters 5 and 6), we discuss factors that lead to the barri or opening of awareness. We conceptualize an ever-shifting surface on which previously inaccessible material becomes consciously accessible. The rate of shifting depends on how open to change an issue is or how entrenched an aversive pattern may be. By providing an amenity of safety through the systematic application of the empathic mode of perception, and by attending to the patient’s affect and to the self-object experiences being sought, optimal circumstances are provided for the patient to explore, ever more deeply, his or her unconscious world. In addition, when the analyst’s presence remains minimally intrusive, a minimum of introgenically rooted opposition is stirred up. In this way interactively organized resistances are kept to a minimum. The delivered message can contain all the message required for the exploration of the moment in an ongoing treatment because, as analysis progresses, the patient feels less need to maintain a protective privacy and a defensive withdrawal. As the surface constantly shifts, the message will contain ever more personal, meaningful material.

The previously described illustration (87:1:3) of the analyst’s empathic grasp enabling Nancy to access a “devastating sense of aloneness” also illustrates the shifting surface of Nancy’s experience. Her communication, “I am painfully alone,” was heard as the message. At that point, the analyst did not assume or interpret that Nancy was warding off any other feelings toward him by walling herself off, that is, through a defensive withdrawal into aloneness.

5. Filling the Narrative Envelope

Filling the narrative envelope (Stern, 1985) refers to activities whereby the analyst asks orienting questions: who, what, where, when, and
such information may be necessary at a particular moment so that the analyst can better grasp the patient’s narrative.

The narrative envelope contains the themes and variations of lived experience from the late toddler period on. The elements of who, hat, where, when, and how are organized into a temporal structure having a beginning, middle, and end. The relative sophistication of these elements depends on the development of cognitive capacities. But by the age of two or three the central features of this organization can be recognized in speech and dreams. The richness of variation of the narrative increases from simple early schemas, the somewhat stereotopic scripts of three- to six-year-olds, evoking in complex, imagination stories.

The finding that lived experience is remembered in the form of narratives or event schemas (Nelson, 1986) has direct significance for analytic technique. Caregivers and infants comprise a system of mutual influence. In early life the experiences on which narratives are based are mutually constructed. Caregivers immerse the infant in a world of communicative looks, sounds, expectations, and procedural predilections. Each partner is also impacted by the temperament of the other.

The shadow of the other also falls onto the agency of the self—when experiences and the memories abstracted from them are organized primarily as though the individual is alone. Thus mutual influence, each partner’s motivational systems being impacted by the other’s, is built into human experience (Mitchell, 1988; Stolorow et al., 1987). This fundamental relatedness of self to others, organized and communicated in narrative form, provides the basis for treatment. Prior experience of an aversive nature is similarly organized, the tendency toward omission and disjointedness in the narrative is increased. The expectation of mismatched responses is also in play. The cues we use to unravel repressed or disavowed motives, fantasies, and beliefs often remain meaningless fragments unless incorporated in a relatively coherent narrative of an event or in a dream. No matter how symbolically rich a patient’s slip, specific association, or isolated dream element may be, we cannot enter the state of mind of the patient without an episodic schema or representation into which to place the symbol. In fact, we have tended to regard a patient’s ability to relate experiences in coherent affect-rich narratives as an important facet of psychological mindedness and a major contribution to successful therapist–patient matching.

The timing and technique of helping patients to relate their past, current, and immediate experience in organized renderings of who, what, where, when, and how requires tact. Analytic participation can range from merely indicating empathic sensing to encouraging the treatment process by asking for examples or further elucidation of an unfolding story. By remaining open to emendations of our organization of the analytic experience, we can encourage an equal openness on the part of the patient. At times, the questions who, what, where, when, and how may be experienced by an analyst as an intrusive, demanding, or intrusive. Generally, a disruption resulting from questions about narratives may be easily navigated and require minimum exploratory efforts for repair. Occasionally they may be massively disruptive. In the latter case, both the analyst’s propensity to become disorganized as a result of any initiative of the analyst and the possibility that the analyst “fled” from a particular intimate moment into an “information gathering” mode need to be considered.

The analyst successfully helped Nancy to fill the narrative envelope when Nancy stated that she looked at her analyst from the couch to be reassured (83:1:16). Uncertain what she meant and needing her lead to orient him, he asked, “Reassured in what way?” Once oriented, he could address Nancy’s need for attachment and explore the need through further inquiry. The analyst did not assume that her need for reassurance necessarily indicated infantile dependence, or masked hostile, voyeuristic, or seductive feelings toward him. Similarly, in the third hour of that sequence (83:3:19), the analyst inquired “In the imperfections you experience me as having, is the one about my going away the most problematic at this time?” He implied that the narrative of her complaints had come across to him as discursive and that identifying the central complaint was necessary for him to be able to understand her main meaning.
6. Wearing the Attributions

Given our overriding interest in maintaining an ambience of safety, we must consider the extent to which a patient's negative or positive fantasies about the analyst can disrupt the analytic dialogue. These attributions by the patient may be contrary to the analyst's view of himself or herself or of "reality." Both the analyst's countertransferencia and a theory that places a premium on "defining boundaries and supporting reality" may prompt the analyst to confront these attributions in order to promote realistic perceptions. In contrast, we encourage the analyst to "wear the attributions."

When a patient indicates that the analyst looks more tired than usual, appears angry or pleased, is looking forward to a vacation, or showing interest in the work, the analyst must try to see himself or herself as experienced by the patient. The clues that the patient picks up about the analyst's feelings and character often point to expectations and areas of interest from the patient's prior lived experience and provide associative pathways to experiences within the initial exchange. The analyst, with attention wandering over the patient's attribution, can often acquire unexpected information about his or her therapeutic approach is regarded by the patient. The analyst's self-awareness can be expanded through intuitive responsivity in wearing attributions or engaging in an enactment. These are times when analysis facilitates an exploration of both partners' experiences and motivations each trigger in the other.

In recommending that the analyst wear the attributions, we advocate neither verifying the patient's fantasies nor asking the patient to collude with the analyst in an overt "pretense." Rather, we advocate the widest possible openness to a consideration of the attribution having an intermediate source in the clinical exchanges. Once analyst and patient regard the attribution in this way the implications of these attributions for the patient can be explored. Several beneficial consequences follow when analysts open themselves to a full consideration of patients' attributions. First and foremost, the analyst's openness and interest promote an exploration of intersubjective aspects of the transference that is less likely to occur if an assumption of distortion and projection on the patient's part introduces a critical, unspoken voice into the proceedings. Second, a sense of continuity maintained within the session. Whatever material the patient introduces, including qualities attributed to the analyst, is open to exploration—irrespective of its manifest or "interpersonal" effect. The exploratory ambience and its safety are maintained for the patient.

Third, it provides an opportunity for "play" within the analytic session. The fact that the analyst is "wearing" the clothes supplied by the patient cements a special bond between them. Such "playfulness" can promote intimacy or become a source of danger. In either case the analytic dialogue is furthered as the effect is then explored.

For example, in the first session presented (83:1:3), Nancy challengingly portrayed the analyst as perversely exposing her and herself to sexually stimulating talk. The analyst took on the issue (83:1:4), "What you asked before, does it put me at risk for getting out of control?" Nancy responded (83:1:5), "That's a possibility I see others. You have these feelings—pleasure, excitement." The analyst then wore her attribution (83:1:6), "That I get stirred up as a result of what you're talking about." However, in this instance the analyst could not sustain being the recipient of the patient's fantasy that he perversely enjoyed the prospect of pushing her toward the limits of her ability to control herself. Instead, he moved away from the "heated" issue of his sexual arousal and focused on depicting himself as a "mentor."

7. The Joint Construction of Model Scenes

Analyst and patient construct model scenes to organize the narratives and associations of the patient, to capture important transference configurations and role enactments, and to further explorations of the patient's experience and motivations. Model scenes can be derived from a variety of sources, such as a theme from literature; a dream image; a fantasy; or a longstanding conflict, fear, or expectation of the patient. In the analysis of Nancy, three model scenes were derived from traumatic childhood events from different developmental epochs. These scenes came to be understood by her and her analyst as occupying pivotal positions in her motivations. They were:

- a memory from Nancy's fifth year, sitting on her father's lap and then suddenly being banished. This memory was gradually elaborated to include a construction that Nancy felt her father's erection, believed herself to be bad, the cause of his discomfort, and therefore was banished from his lap. This model scene thus contains the conviction that girls are seductive unless they go to great lengths to prevent it. Furthermore, Nancy and her analyst inferred that boys and men were seen as helpless reactors to a girl's revealed bodies and charms. Thus, if a man becomes aroused, it is the fault of the seductive woman and he bears no responsibility for it.
• a construction or reconstruction of Nancy tugging at her mother's\g and sensing the stiffening of her mother's body as she resisted\ancy's importuning. This scene was gradually elaborated to include\ancy's memory of her mother lifting Nancy's brother onto the\tchén table, and asking him to sing to her. When Nancy climbed\o as well, her mother told her that she couldn't sing. These model\enes contained the theme that Nancy was with a caretaker who\as capable of reaching for, lifting up, affirming, and praising another\ild, a boy, but not her.
• memories of Nancy's brother using her body to masturbate\gainst and insisting that she cooperate in the masturbation. This\ene provided a further enhancement of Nancy's memories of sitting\her father's lap and revealed an additional reason for her inten-
ded sense of shame, guilt, and worthlessness.

These three model scenes will be elaborated with clinical detail\hapter 7 where their relevance to sexual abuse and the erotized\nsference will be discussed. The three scenes, taken together,\ustrate a family collusion that placed Nancy in conflicted, no-win\rcumstances. The over-all analytic process can be looked upon as\working through of the model scenes derived from her expe-
riences of overt sexual molestation by her brother, covert sexual\volvement by her father, and longings for nurturance derived from\eriences with her mother.

8. Aversive Motives (Resistance, Reluctance, Defensiveness) Are a\ommunicative Expression to Be Explored Like Any Other Message.

Resistance analysis has held a major place in the development of\alytic technique. In fact, it provided one definition of what makes\reatment "psychoanalytic." We do not place a premium on resis-
tance analysis or defense analysis, or on analyzing a patient's reluctance\veal material. So, what is the place of resistance in the user-
endy technique?
We understand "resistance" from the perspective of the five mo-
tional systems. Resistance, defensiveness, and reluctance all illustrate\ees and aspects of aversive motivations. When resistance is viewed\n an aversive motive that dominates the patient's goals at a partic-
time, then the patient's "resistiveness" is understood as a need\ react with a form of antagonism or withdrawal. The aversive\ivation is then regarded as on a par with other needs that are\ing explored. Some aversive motivations are themselves goals of

analysis. We are pleased when a patient such as Nancy can consol-
idate a response of exerting power to oppose abuse and can be\ffective in engaging in controversy. We are pleased when Nancy\nrecognize the disadvantage to her of trying to overcome obsta-
cles by rash attempts to dazzle and instead applies self-restraint.\e aversive motivations that are traditionally conceptualized as "resistance" in analysis are reactions or responses to experiences that\igger negative affects and threats to the cohesion and vitality of\e sense of self. The aversive experiences may be expectations of\rencurrences of past traumatic interactions or actualizations in the\litical exchange. To view the occurrence of resistance during the\litical exchange—the patient's or the analyst's—as reactive, is of\icular importance in maintaining the analytic ambience. Then\he trigger for the aversive motivation in the session, as well as the\atient's (or analyst's) tendency to react aversively under certain\stances, is open for exploration. Patients are not made to feel\y they are at fault for responding in a manner that interferes\ith the analyst's attempt to help them. The goal shifts from an\empt to set resistance aside and get to the "real" material that\es sequestered or to make conscious unconscious mechanisms of\ense. The goal is also not to make resistance disappear, which is\ssible in any case, but to explore any experience of aversion\hat can be brought to the foreground of the analytic work. Thus,\n our view, defense interpretation is not a special or central aspect\f analytic work. Each motivational system is explored when it is\ominant.

When we discern from a patient's associations that he or she\esires companionship or to be mirrored or to find a sexual partner\or to be better able to complete a work task, we try to help him or\er discover the context in which the desire arises and its present\nd past meanings. We approach a patient's tendency to express\nagism and withdrawal in a similar way—we ask what the context\s in which the aversion arose and what is the present and past\eaning of the particular form of its expression. To achieve optimal\priciation by the patient, a desire for companionship or mirroring\r a sexual partner or to achieve competence must be interpreted in\n a manner the patient can recognize and experience from his or her\oint of view. Similarly, to be comprehended effectively, manifesta-
s of antagonism and withdrawal must be interpreted in a manner\he patient can recognize and experience from his or her point of view. A significant difference is that the motivations of the physi-
logical, attachment, exploratory-assertive, and sensual-sexual systems
are most often experienced as going toward a desired goal, whereas
the motivations of the aversive system are most often experienced
as dealing with or getting away from an undesired state. Clinically
we find patients giving signals of distress and appeal that are easily
recognizable as indications of aversiveness and a call for a response
comparable to a child's signal to a parent for remedy and relief.
Nancy often indicated directly or by a loss of concentration, a
diminished affect, falling into silence, or bodily rigidity that some-
thing the analyst had said or something she was recognizing was
triggering anger, fear, shame, or sadness. Frequent examples of
this occurred during discussions that centered on her disappointment,
anger, and criticism of her mother, brother, and aunt. In
these situations, the analyst's task is relatively straightforward. The
analyst can observe from the more traditional position of the outside
observer and then, placing himself or herself in the patient's perspec-
tive, offer a question or a suggestion about the nature of the aversive
response and its triggering source. For example, the analyst
often would ask Nancy: Do you have the sense from your silence
now that we got into the troubling area of your hurt feelings
about your brother and then your desire to not put your devotion
to him in jeopardy? Very often the aversiveness will take on
more complex form, one embedded in a repetitive, resistive pattern.
This pattern of resistance derives from a habitual triggering of an
expectation of something aversive occurring whenever a particular
need or desire arises. Conscious awareness is rarely complete. Either
he need or desire, the expectation of the aversive response, the
incidents of the expectation, or the existence of the entire pattern
may be inaccessible to awareness. Although repetitive, these
patterns, especially those that seem adaptive, may be difficult for
attent or analyst, or both, to recognize, or, if recognized, to
iscern the full meaning of. Because they are difficult to identify,
yey tend to become habitual in the treatment and appear as roles
which analyst and patient play out their parts with limited
awareness. Nancy often returned from a weekend or holiday break
a state of upset or depression. She would describe an event at
lab or at school that had upset her. The analyst would take
the event as the trigger for her distress and a useful explo-
ation would follow. The repetitiveness of this pattern was not
cognized for some time, with the patients playing out their expected
roles of troubled patient with complaints, helpful analyst ready to
ke up the problems. Once the analyst did recognize the pattern,
never, Nancy reacted to his inquiry with obvious reluctance and

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fear. The fear alerted the analyst to her concern that something
bad would happen. Both Nancy and the analyst were familiar with
her fear of being shamed for complaining, but this pattern indi-
cated something more. The analyst got his cue from the role he
had taken, as he began to be less willing to attend the upsetting
event of the weekend and Nancy became more upset as a result
of his subtle shift. They then pieced together that Nancy had the
fixed expectation that the analyst had spent his weekend delighted
to be free of the burden of her care and that on his return he
would continue his indifference to her as long as he could. She
needed to ensure his reengagement with her by arousing his anxiety
over her distress. Without it he would treat her as her parents did,
relying on her ability to take care of herself and then out of sight
out of mind. The understanding Nancy and her analyst achieved
resulted not in the elimination of the pattern, but in its being
more readily acknowledged and worked with. The 85:3 hour began
with Nancy's acknowledgment of progress, but her usual weekend
depression. She recognized that if everything was in order, she
would have no excuse to avoid the sexual problems that she had
been considering. She became limp, still, and silent. The analyst,
rather than pursuing the obvious purpose of the resistance, tried
to encourage Nancy to explore her experience. Nancy: "Fog. I feel
I'm in a fog, when I try to think about my sexual problems." The
analyst, taking this as a full recognition of her aversiveness, invited
her cooperation to explore it and asked "Can you penetrate the
fog to sense any of the factors?" This led to a flow of useful asso-
ciations.

In stating the technical principle that aversive motivations are
explored like all other motivations, we move away from the tradi-
tional importance given to repression, isolation, projection, identifica-
tion, and negation to get to a latent conflict. We believe that as the sources
of aversive experiences, especially those occurring during the treat-
ment, are explored, the patient's increased sense of safety will guarantee
the relative openness of the path to awareness. Alternatively, we place
great significance on the problems that arise during role enactments.
Many of these arise from repetitive patterns of aversive responses
embedded in relational schemas, such as Nancy's need to bind the
analyst to her through guilt and anxiety over her suffering and fail-
ures. Any of a long list of comparable responses to aversive experiences
and expectations may pull the analyst into affective verbal and nonver-
bal enactments. The initial problem often is recognizing that what is
happening in the clinical exchange is the result of deception by denial.
and disavowal of the patient to himself or herself and/or the analyst or the analyst to himself or herself and/or the patient. Or it may be that a quality of irritability is mounting by virtue of the subtle use of provocation by either partner or threats of harm to the self by the patient. Emptiness in the exchanges may be due to submissiveness, dissociation, suggestibility, or overidealization. A subtle form of arousal may result from seductiveness under a variety of guises. States of difficult-to-explain confusion in the exchanges may result from pseudostupidity, rapid shifting of positions, and frequent contradictory stances. The analyst may feel crowded out by being talked at (not with), or may feel encroached on by shadowing or by the patient's sticky preoccupation with him or her. This partial list conveys the often subtle forms of resistance that require analysts to be drawn enough to get clues from their experience, and then to identify the particular trigger to the intersubjective context that has developed. The next step, often the most difficult, is to help the patient to recognize the experience from the patient's point of view. Then only then do we believe effective, nonblaming, nonshaming interpretation can take place. The interpretation is focused on the intersubjective context and the mutuality of triggering in the interplay of enactments.

The possible triggers for the patient's aversive reaction are derived from the contributions of both analyst and patient. We take into account the analyst's transferences, empathic ruptures, narcissistic vulnerabilities, misattributions, and blind spots, as well as the patient's propensity to react aversively, under circumstances when other motivational systems could be, or might have been, activated. The patient's aversive responses often are triggered by breaches in his or her expectations. Such breaches occur when expectations of having a selfobject experience are ruptured—whether these expectations are in the foreground or the background of the analyst-patient interaction, investigating fluctuations in selfobject experiences simultaneously repairs—or breaches and addresses the aversive motivations.

1 Slavin and Kriegman (1992, 1994) correctly state that inevitably there are times when the interests of therapist and patient diverge and clash. "We tend to talk as if the therapist's discipline, role, and understanding can enable therapist and patient to ascend the self-interested efforts at influence which are part and parcel of all human relating... Both patient and therapist must confront the elaborate system of protective self-deceptions that maintain their own subjective bias. This confrontation forms crucial—but greatly underemphasized—dimension of the treatment process" (1994, 2).

9. Three Ways in Which Analysts Intervene to Further the Therapeutic Process

Based on empathic listening, the analyst's most frequent interventions are presented from within the patient's point of view. We do not propose that the analyst simply echo the words of the patient. Rather, the analyst selects and focuses, highlights and questions, articulates subtle or "hinted at" affects and states, and speaks out transference implications of the patient's associations. Often the intervention will follow the form of "Is this what you are telling me?" or "Can you say more about that?" or "Do you mean?" These interventions are designed to continue the flow of associations, promote the paths to awareness, and enlarge the areas of material available for investigation. The dialogue between analyst and patient increases the terrain available for exploration—terrain that had previously been unavailable or inaccessible.

For example, in session 87:1, Nancy elaborated on her sense of "moral failure." This sequence also illustrates the analyst speaking from within the patient's experience. Having discerned the patient's experience, the analyst is then prepared to convey what has been discerned. Nancy spoke of her "trouble with Jane" and her feeling of depression that she is "not special in an intimate way with anybody." She continued, "It's ironic that in the middle of the [church] service, I'd be so aware of feeling alone. I reminded myself I have lots of friends who love me. I was overcome with hopelessness nevertheless—a fear I'd never be close, always on the fringe." In her lengthy opening monologue, Nancy alluded to feelings of jealousy about Jane's special relationship with the minister, Charles. In addition, she complained about her "aloneness" in spite of having lots of friends who love her. Neither of these issues were inaccessible to her. Given a receptive ambience, Nancy can be expected to explore these problems in her own time. The analyst could therefore articulate what he had discerned about Nancy's affect, motivations, and reparative strivings. Thus, having sensed himself into Nancy's affect state and motivations, her needs for attachments and affiliation, he could speak to her from within her point of view. He said (87:1:2), "Would that feeling pressure you to want to try again with Jane and your aunt?" Nancy's response justified how and where the analyst positioned himself vis-à-vis her. She continued (87:1:3), "Perhaps. I do feel a devastating aloneness and I feel it as a consequence of my own actions."

Another illustration of addressing the patient's experience from within the patient's point of view is found in session 89:1. With
termination only about a year away, Nancy spoke about her reluctance to leave the analyst. For a moment she even considered not being well enough to leave so that she could hold on to him. The analyst might have picked up the residuals of Nancy’s dependency. She had considered “flight into illness” to retain a dependent attachment. When she said (89:1:15), “You’re my best friend.” He commented (89:1:16), “It surely is hard to part from a best friend,” thus articulating Nancy’s dominant affect state, affectionate yearnings. Nancy’s ability to struggle with her conflict over her dependent attachment, and her anticipation of loss, was respected. But, more important, speaking to Nancy from within her experience avoided the danger of ushering the patient out of analysis by tilting toward independence over dependence and suggesting that psychological health required renunciation of archaic ties. Understood as a selfobject experience rather than as “dependency,” Nancy’s tie to her analyst can remain and gradually become abstracted and depersonified. As Nancy elaborated later (89:3:11), “I want to be free of you, of Mother. Not dependent on you.” The analyst said (89:3:12), “Just get rid of me.” Nancy continued (89:3:13), “I’m not sure, get rid of being dependent and angry, but still have you to be related to in a more adult, mutual way.”

The dialogue that follows from interventions reflecting the analyst’s empathic listening perspective is, however, never continuous, smooth, or unimpeded. And, no matter how artfully the analyst conveys comprehensation, and no matter how attentive the analyst is to the patient’s affect and selfobject needs, speaking only from this perspective does not an analysis make.

Another kind of intervention required of the analyst includes illuminating a recognizable pattern, or communicating feelings, appraisals, or expressions from the analyst’s own perspective. In these instances, the analyst has shifted from an empathic, interpretive listening mode to an empathic, interpretive observing stance vis-à-vis the analysand’s experience (Lachmann, 1990). This stance is not a departure from the empathic vantage point, but it does stretch it toward a potentially more confrontational interaction. Under these circumstances, degree of tension may characterize the analytic ambience. The patient may be receptive to these appraisals and be just about ready to grasp a new perspective, or he or she may be averse to the intrusions of the analyst’s impressions. In the course of their dialogue, analyst and patient pay particularly close attention to those interventions that have had some disruptive effect.

In session (85:2:5), Nancy spoke at length about her sexual history, her sex play at age 10 with a girl friend, and being sexually molested by her brother. [Pause] “My brother would rub against me. Against my leg, my stomach, until he had ejaculations. I felt very dirty.” The analyst restated her account (85:2:6), “You didn’t have a sense of being appreciated for yourself but for the purpose you served?” Nancy began to speak in generalities (85:2:7), “I’m angry at men for taking women as receptacles. I’m angry at women for being vulnerable enough to let it be carried out, and worse, to invite it.” The analyst now spoke from his perspective, in that he applied Nancy’s general comments to herself (85:2:5), “And that makes you feel bad about yourself that you were inviting it, the alternative of being unnoticed was such a painful choice.”

In the next session, (85:3:1) Nancy said, “When I left Tuesday your last statement made me feel bad.” She then worked herself into a momentary outrage. As her anger abated, she reminded herself that the analyst said that the alternative of being unnoticed was so painful. We regard this sequence over the two hours as an example of the analyst speaking from the vantage point of an observer who was aware of and sympathetic to a conflict Nancy faced between two aversive choices. Her subsequent associations indicated that Nancy was ready to work with this perspective.

A third group of interventions in analysis, which we call “disciplined spontaneous engagements” between analyst and patient, are difficult to classify. They lie within the overall therapeutic frame, but outside the usual pattern of association and reflective response. “Disciplined” refers to a full appreciation of and dedication to the maintenance of the analyst’s ethics and fostering the analyst’s generative intent. “Spontaneous” refers to the therapist’s often unexpected comments, gestures, facial expressions, and actions that occur as a result of an unsuppressed emotional upsurge.

Disciplined spontaneous engagements may be prompted by some untoward event, breach, or miscommunication that requires a human response. Disciplined spontaneous engagements of a dramatic sort were rare in the treatment of Nancy. One was precipitated by Nancy’s demand that the analyst change his way of ending the sessions. The analyst’s authenticity required that he accept that he had unwittingly engaged in a role response to her distressed state. His tone was an attempt at soothing that was indeed patronizing as it played out between them. Implicit in Nancy’s response was the attribution, “You don’t want to face that you are throwing me out by the clock and
want to sugarcoat it. Don't play the saint (mother) with me!" The
analyst, accepting his need to change, then had to deal with his
second problem—his uncertainty as to how to proceed. His sponta-
eneous response was to ask Nancy directly how she would prefer he
attend the session. Her suggestion, "Just tell me the time is up" and
is acceptance (with relief) placed them on a footing of relative equality.

A second disciplined spontaneous engagement occurred when Nancy
saw in a great state of distress, announced she would have to change in the fee arrangement. In this instance, the analyst responded
to the challenge of Nancy's emotional appeal, and the threat to the
continuity of the analysis, by engaging directly in a confrontative
fusil. He regarded his own need as the decisive factor in the engage-
ment, buttressed by his intuitive guess that Nancy was exaggerating
the seriousness of her economic need.

We recognize and applaud the analyst's capacity and readiness to
terve when intersubjective authenticity is at stake—to offer creative,
novative, ad hoc, unplanned, and unexpected interventions. Such
interventions seem to spill from the analyst's mouth, often to the
uprise of both analyst and patient. These moments are best viewed
uniquely constructed between a particular analyst and a particu-
ar patient at a crucial juncture in analysis. They are better left as
ailor-made" moments than converted to "mass-produced" technical
interventions or generalized principles.

However, these spontaneous comments do not have to await some
ecial moment. The analyst's empathic stance, and ability to "play" with
the material presented by the patient, provides the soil from
ich these creative gestures can spring at any moment in an analysis.
For example, session 83:1 began with Nancy's expression of reluc-
ence to engage in the session. She then spoke about her disappointment
the priest who did her conversion. Later, she said to her analyst
3:1:9), "I think of you as my dad. [pause] You represent a verboten
aracter." The analyst responded (83:1:10), "Your father?" The analyst's
mment was packed with more meanings than the analyst had been
are of when he made it. Nancy quickly picked up the broader
lications of the analyst's comment, she said "you, Dad, and Christ"
3:1:11). Such interventions illustrate the analyst's access to his
pan path of increased creativity and spontaneity without loss of
tral over the issues that are salient for the patient. Such inad-
tent double or triple "entendres" are familiar aspects of social
course, but are generally not given sufficient credit in widening
levels of communication between analyst and patient. They illus-
ate the relationship between preconscious mentation and wit (Freud,
1905). In a similar vein, the term, "old-fashioned virtue" (85:1:16)
slied out of the analyst's mouth. Such odd comments are typical
of the vast array of subjectively organized phrasings and idiosyn-
cratic imagery that make every analysis unique. These interactions,
like "It's your serve," defy categorization and range from "jarring"
disruptions of the analytic relationship to "golden moments" or "turning
points" (Wallenstein, 1986) in analysis. Spontaneity, wit, double enten-
dres, and play pave the "royal road" to consciousness.

10. We Follow the Sequence of Our Interventions and the Patient's
Responses to Them to Evaluate Their Effect

In our discussion of the user-friendly principles, we have emphasized
the analyst's role in the therapeutic dyad. In so doing, we have uner-
stood the complex interactive process that accounts for therapeutic
action. The analyst's spoken words, as well as silences, facial and
vocal displays, and other forms of nonverbal communication are part
of the sequence of interventions that affect the patient and contribute
to the organization of the transference. In our view, interpretations
are best not offered in "chunks" toward the end of a session as is
 customary in some analyses. Rather, complete interpretations (Glover,
1955) that cover wish and defense, past and present, transference
and resistance are best reconstructed by analyst and patient and conveyed
piece meal, throughout the session. In digestible bits, the analyst tracks
the patient's affect and association, responds with another construc-
tion/intervention, and then further tracks the patient's response. When
a disruption occurs, attention to its effects takes precedence. At such
points, the analyst makes inferences to understand the nature of the
rupture and his or her role in its occurrence.

We consider a unit of time (a session or a week of sessions) to
provide the continuity necessary to encompass an interpretive
sequence (Lichtenberg, 1992). We include a wide range of inter-
ventions: investigative, confirming, affirming, reflecting understand-
ing, explaining the process, and developing and repairing ruptures
(Lichtenberg, Lachmann, and Fosshage, 1992).

We have retained the term "interpretation" because of its histori-
cal roots in psychoanalysis. But, more important, we recognize and
include the multitude of facilitative interventions that are usually not
credited with contributing to therapeutic action. Recognition of the
wide range of interventions that contribute to therapeutic outcome
(for example, see Wallenstein, 1986) broadens the concept of inter-
pretation, more accurately represents psychoanalytic technique as it
is practiced, and recognizes the interactive process that constitutes
therapeutic action. Through the sequence of interventions, the analyst conveys a coherent sense of purpose and the interventions thereby attain a cumulative effect. The back-and-forth of the analytic dialogue deepens the interpretive sequence, transforming both participants in the analytic process.

Interpretive sequences in Nancy’s treatment can be tracked in sessions 83:1 and 83:2, where the work of prior sessions comes to fruition. Nancy’s sense of “badness” and decadence slowly gave way. Her sense of her analyst and herself began to shift. Sometimes a line of interventions leads to “dead ends.” For example, in the first session (83:1), the analyst followed Nancy’s associations in response to his interpretation that she wanted to use him as a model for regulating sexual arousal (83:1:8). After a compliant “could be,” she left this theme. Her subsequent associations were not about using the analyst as a model, but to the analyst as a “verboten character” (83:1:9). The analyst sensed that his intervention was essentially nonconsequential. In such circumstances the analyst may lie low and then recite to discern the patient’s concerns.

Perhaps the intervention about “regulating her sexual arousal” was derived from a then current concern of the analyst, rather than based on insight into Nancy’s motivation. She did not react affectively to t, neither aversively nor enthusiastically. Although Nancy sensed that her analyst was “off,” she did not respond as though she experienced a empathic failure. Even if she had such an experience, it was apparently not a serious enough “failure” to require time for self-righting or mutual exploration. Both analyst and patient let the intervention pass without further notice as they attended to other associations.

In the next hour (83:2), the interpretive sequence covered Nancy’s dream. As the analyst followed Nancy’s associations during the hour, he recognized that Nancy had related her dream at the beginning of the hour. She then spontaneously came back to it later. He concluded that both the dream and her associations contained a common motivational thread—aversiveness to a man whom she experiences as a sexual provocateur, but who denied his responsibility for the sexuality of the encounter. In relating the theme and her associations, the analyst discovered that he and Nancy had enacted the very issue he was addressing. He was the “provocateur” in “relating” with Nancy. She had remained more passive and she and her analyst thereafter fell into an enactment whereby Nancy could plausibly perceive him as a provocateur.

In this interpretive sequence, the analyst tracked Nancy’s affect, associations and reactions, and potential ruptures in their dialogue.

He also tracked his own affect and associations, and considered how his experience may further, obstruct, or enact the issues he and Nancy were addressing. Our attention to the interpretive sequence aims at keeping the subjectivity of both analyst and patient, as well as their “intersubjective conjunctions and dysfunctions” (Arwood and Stolorow, 1987), in the forefront of the analyst’s attention.

We chose a somewhat arbitrary starting point for the interpretive sequence described, Nancy’s sense of “badness.” The sequence led toward Nancy feeling blamed, “bad” and “responsible,” when men felt sexually aroused by her. She expected them to hold her responsible for having provoked them. In the course of the exploration of this theme, the analyst made interventions that were off the mark, but which, when recognized, permitted the analysis to continue. For example, in the enactment of “blameless” provocateur-analyst and responsible seductress-patient Nancy felt increasingly “trapped” (83:2:21). For the moment, the transference became “real” to Nancy.

The analyst attempted to extricate himself and Nancy by an “empathic” comment, “Your sense of being trapped in a situation that seems manifestly unfair.” However, he implied that her sense of unfairness was entirely her construction. Nancy, understandably, responded with anger (83:2:24–25), “What do you mean seems?”

In the following session, Nancy was still angry. She likened the analyst to her sadistic brother who pulled the wings off a fly and watched with pleasure as it squirmed. He was a “scientist” and sadist, a clever deceiver. The safety of the analytic relationship enabled her to simultaneously experience her analyst as a sadist who enjoys taunting her and as the benign, caring figure who has demonstrated that he can accept her experience. He has done so by having articulated her experience from allusions, hints, and scattered associations, and has done so from within her perspective.

Nancy cried when she said to her analyst, “Before this when I got really angry with you I could tie myself down by reminding myself you seem to be a decent man. You look benign” (83:3:1). The analyst responded, “If my very presence and my benign appearance invite your interest and curiosity, that becomes part of the problem” (83:3:4). The interpretive sequence continued throughout the session with the analyst “wearing” Nancy’s attribution of him as a sadist, tempter, and cheater (“If my very presence . . .” [83:3:22]). Throughout this interpretive sequence, Nancy’s experience with her father, mother, and brother, and her current experience with her analyst (her ability to articulate her fantasies and fears about her analyst), have become gradually consolidated.
Our ten principles of technique are formulated to achieve the traditionally recognized analytic goals of expanding the patient's awareness and self-reflection, forging links between the patient's past and present that provide an emotionally rich context for current experience, and decreasing impediments within the patient to past, emotion-laden experiences. We propose that these principles further these goals by increasing the likelihood that patient and analyst can navigate their interactive process with a minimum of interference from theoretical rigidity and a maximum of therapeutic creativity.

Commenting on Psychoanalysis and Motivation, Lawrence Friedman (1995) states:

If analysts perceive through Lichtenberg's prism, patients may see the analyst as more specifically empathic, more readily at the service of the patient's momentary state. [The analyst's] non-authoritarian flexibility will make him seem less professional, more "into" his patient, less distant . . . and less judgmental . . . because "bite-size" motivations [even when supplemented by model scenes] are just like facts of neutral nature [pp. 444-445].

Our principles of technique can lessen the "suspiciousness" that often characterizes psychoanalysis. When psychoanalytic treatment is viewed through the prism of the motivational systems, the often interpreted concealing, defensive, and resistive efforts of the patient can be seen as expressive. This theoretical feature can impact treatment enormously. When the analyst follows a theoretical model that does not place a premium on suspiciousness toward the resistive, voidant patient, the analyst is more likely to become aware of his or her feelings of affection, anxiety, and anger toward the patient.

Our principles of technique are designed to be friendly toward both the patient and the analyst. As analyst and patient engage in an exploration of the patient's states, affects, moods, and the intrapsychic and intersubjective dimensions of their interaction, these principles also place the analyst in an optimal position to access his or her own subjectivity.

5 Affective Experience
The Golden Thread in the Clinical Exchange

Every intervention made by the analyst has attached to it the implied question to the patient: "Is this what you are trying to say that you feel?" (Boesky, 1990, p. 577).

Affection amplifies experience. They either make good things better or bad things worse (Tomkins, 1962, 1964).

Object love strengthens the self, just as any other intense experience, even that provided by vigorous physical exercise, strengthens the self. Furthermore . . . a strong self enables us to experience love and desire more intensely (Kohut, 1984, p. 53).

These three references approach affective experiences as they emerge in psychoanalytic treatment from different angles. They provide a scaffold for the discussion that follows. Boesky (1990) proposes that every analytic intervention addresses feeling as conveyed by the patient and as received, understood, and communicated by the analyst. We develop Boesky's comment by proposing that learning what the patient "feels" involves exploring a continuum ranging from transient categorical affects, through moods, to all-engrossing states of intense affective experience.

Each affective experience involves a feeling, a physiognomic expression, and, often in addition, an autonomic nervous system reaction. By "categorical affects" we refer to the experiences of enjoyment, happiness, pleasure, anger, fear, sadness, shame, humiliation, embarrassment, guilt, distress, contempt, and disdain. These affective experiences are relatively easily recognized and labeled by both experiencer and observer. They are commonly triggered by an identifiable source. Thus, when Nancy was angry at her dissertation advisor's failure to respond in a timely fashion, the analyst and she could recognize the source and the easily understood form of the emotional response. The term moods, in our usage, refers to affect experiences that last longer and are often more pervasive. For example, Nancy's anger when triggered by Father Rocco's failure to respond to a phone call would at one point dissipate into relief when he called back a day later. But after repeated failures, chiding, and discouragements,