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, avoidant 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).

*Affects amplify 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 autonomous 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,
her mood became one of prolonged low-keyed resentment and disillusion. Linkages to past comparable experiences and transference associations made her moods more complex and longer lasting. By affective states, we refer to more intense all-engrossing affective experiences, those that are so all-engrossing that cognitive capacities are constricted and compromised, like those of a child during a temper tantrum. Only the immediate sensing of the affect has cognitive significance. Affect states may be short-lived or as enduring as malignant hatred and grudge carrying after a perceived narcissistic injury. Nancy's description of states of bone-crushing depression during weekends are examples of an incapacitating experience. She would be unable to work, finding it difficult to follow her exercise plan, write letters, or talk with friends.

Analysts find that their interventions are or are not consonant with the particular kinds of responses that help to further explore patients' communications—each position on the continuum calling for differing facilitative responses. We further assume that interventions, through their impact on the affective experience of both participants, contain a transference-countertransference dimension in which emotion is central to the exploration of the motivations underlying the clinical exchange.

Every clinical exchange constitutes a lived experience for both analyst and analysand. Consistent with Tomkins's (1962) perspective, when an analyst affirms a patient's positive affect, the good experience is enhanced; and when an analyst is drawn into an affective state of rage, shame, or hopelessness, the clouds become even darker. The significance of this amplification process will be apparent when we detail the continuum of positive to negative affects, moods, and affect states. By an appreciation of the significance of affective experience, we are in a better position to consider the therapeutic implications of the analyst's encouragement, recognition, positive and negative enhancement and containment of the emotional aspect of all clinical exchanges.

Kohut (1984) proposes a reciprocal relationship between the experience of emotion and the experience of one's self. The sense of self is strengthened through invigorating, intense, heightened, positive affective experiences. A strengthened sense of self, in turn, allows one to experience affects more intensely. The strengthened self may then respond to and communicate affects more clearly. In so doing, one's own affective experiences may be more clearly appreciated reflexively and thus be more available for sharing and conceptual understanding in the clinical exchange.

A CONTINUUM OF AFFECTIVE EXPERIENCE BASED ON DIRECT CLINICAL OBSERVATION

The significance of emotions in psychoanalysis has seesawed from its initial centrality in abreaction as strangled affect caused by traumatic events. The salience assigned to affects diminished greatly during the period when the emphasis was on drives. Affects then were considered as derivatives or by-products of the drives. Greater significance was then assigned to anxiety in the structural hypothesis. As a signal of potential danger to the ego, anxiety became the basis for the automatic institution of defensive measures. Within this core hypothesis of ego psychology, theorists wrestled with the place of emotions (Rapaport, 1953; Spitz, 1957). The modern era of affect theory began with Tomkins (1962, 1964). With many valuable contributions in between (Stern, 1985; Emde, 1988a, b) the modern concept has led to comprehensive reviews and reformulations of great merit (Shore, 1994; Jones, 1995). We place our own essential view in common with this contemporary trend based on infant research, neurophysiology, and clinical observation. Here, however, we choose to follow a different course. We will take a "naive" approach based on common experience in order to make a particular point that is important to our approach to the clinical exchange. We will develop our thesis that discrete or categorical affects, moods, and affective states each have different impacts on both patient and therapist. This assumption is necessary to substantiate our belief that any clinical experience requires the consideration of not only the traditional intrapsychic and intersubjective perspectives but also a third perspective—an assessment of the affective-cognitive state.

Although we recognize that affective experience changes in complexity from those that are innate and directly triggered in infantile life to subtle couplings of feelings and symbolic cognition and appraisal, we have chosen to base our designations of affective experience on ordinary verbal usage by adults. That is, we use terms that patients would use to describe their inner experience and that we would use to call attention to their affective experiences and our own. We have chosen not to follow any of the available attempts to distinguish between affect, feeling, and emotion (Basch, 1976), innate affects, affect auxiliaries, and affect coassemblies (Tomkins, 1962, 1964), primitive affects and derived emotions and feelings (Kernberg, 1992) or affects in schematized forms such as signal anxiety and unconscious guilt (Freud, 1926), an affective core (Emde, 1983), organismic distress (Mahler, 1968) or basic anxiety (Sullivan, 1953).
We acknowledge the validity of the linear empirical effort that underlies each of these efforts at a scientific classification. The approach we take is guided by our belief that in adults affective experiences and their designators are individualistic. For example, what seems like guilt to one person may seem more like shame to another. Thus the pairings and diagrams we will offer are, of necessity, arbitrary in their specifics. Other choices could easily be made for the pairs and groups we will present as exemplars of our main goal—to call attention to the distinctions among discrete affects, moods, and affective-cognitive states.

Affective experiences tend to suggest pairings of positive and negative, or hedonic and anhedonic as shown below.

<table>
<thead>
<tr>
<th>Affect</th>
<th>Designator</th>
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<tbody>
<tr>
<td>Affection</td>
<td>anger</td>
</tr>
<tr>
<td>Contentment</td>
<td>envy</td>
</tr>
<tr>
<td>Pride</td>
<td>shame</td>
</tr>
<tr>
<td>Happy</td>
<td>sad</td>
</tr>
<tr>
<td>Courage</td>
<td>fear</td>
</tr>
<tr>
<td>Moral goodness</td>
<td>guilt</td>
</tr>
<tr>
<td>Energetic</td>
<td>tired</td>
</tr>
<tr>
<td>Self-assured</td>
<td>insecure</td>
</tr>
<tr>
<td>Competent</td>
<td>ineffective</td>
</tr>
</tbody>
</table>

When a patient states that he or she is sad, this feeling is apt to be paired by patient and analyst with happy—which, of course, sad implies the patient is not.

An imaginary line representing affect neutrality can be drawn between the principal pairs (Figure 1). The positive affects that ordinarily we observe people seeking opportunities to experience are above the line and those that people ordinarily are aversive to are below the line.

<table>
<thead>
<tr>
<th>Affect to mood line</th>
<th>More intense, longer lasting, more situational resistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affect to mood line</td>
<td>More intense, longer lasting, more situational resistant</td>
</tr>
</tbody>
</table>

and below lines are boundaries that delimit affects that are experienced sometimes as less intense, evanescent, and responsive to situational change (those nearer the neutral line) and sometimes as more intense, longer lasting, and more resistant to moment-to-moment situational change (those away from the neutral line). The affective experiences or moods away from the neutral line are often influenced by temperament (for example, shyness and shame-proneness) and are often considered an identifying aspect of character or personality.

During the clinical exchange, feelings within the discrete affect to mood lines of both analyst and analysand are in or relatively accessible to awareness. When one affect is barred from awareness because of aversiveness—for example, anger is suppressed or lightly repressed because of shame, recognition of the shame and its purpose will allow both shame and anger to become consciously experienced. Emotions between the discrete affect to mood lines are relatively easily available to free association, reflective awareness and expanding insight. Those affective experiences that lie outside these lines, those that constitute state changes, present greater challenges for analytic work (Figure 3).

**WHAT RESPONSES BY THE ANALYST ARE EVOKED BY DISCRETE AFFECTS, MOODS, AND AFFECT STATES?**

Those affective experiences above the neutral line—affection, contentment, pride, courage, optimism, goodness, energy, assurance,
effectiveness—generally convey to the patient a sense of safety for telling the analyst his or her thoughts. Alternatively, distrust, envy, shame, fear, sadness, guilt, passivity, insecurity, and ineptitude generally lead to guardedness in self-revelation. Because discrete affects and moods are relatively sensitive to context and open to self-reflection, their appropriateness to current conditions is often easy to assess.

A simple confirmatory response will tend to provide patients with an affirmation of a positive affect or mood. Negative affects and moods can be confirmed (or disconfirmed) as an appropriate response to their trigger by the analyst’s interest and inquiry (Figure 4).

The type of expectation that may lead to either a discrete positive or negative affect or mood can then relatively easily be brought into awareness, revealing transference configurations of varying intensity and historical longevity.

Affectively intense states likewise carry experientially a sense of safety or guardedness. Rapture, imperturbable self-satisfaction, self-perfection, reckless abandon, elation, hauteur, frenzy, grandiosity, and omnipotence all carry the patient along on thoughts and behaviors that seek neither counsel nor question. Safety is experienced as dependent on the preservation of the state. Interventions aimed at deflating the aggrandizing or dangerous aspects of the state expose the analyst to being regarded as the danger, rather than the state itself. Prolonged and/or intense suspicion, hatred, irreconcilable dissatisfaction, mortifying shame, terror, depression, self-pity, abjectness, apathy, victimization, and inadequacy all tend toward guardedness as a general orientation. Challenging its validity or even inquiring as to its source will often place the analyst at risk for being implicated in the aversiveness, whatever its origin.

The affective states conveying a sense of safety and those conveying a sense of guardedness are paradoxically similar in that both are a source of resistance to investigation and change. The patient who is experiencing a state of rapture, hyperidealization, and various forms
of self-aggrandizement will be exceedingly reluctant to reflect on, examine, or lose the temporary sense of security he feels. Much has been made of whether these states, often lumped together as “grandiosity,” are defensive or the result of deficits. We feel that the clinically significant fact about them is that their origins usually lie in a combination of prior difficult or traumatic experiences, that conflicts invariably play a part in their development, and that each instance requires investigation as to its meaning. Reluctance to change is inherent; thus an analyst’s failure to recognize the patient’s insistent effort to preserve the sense of safety is apt to be experienced as an empathic failure. The perceived empathic failure in turn leads to increased defensiveness—now iatrogenic in origin—and often to a change to an aversive state. To complete the paradox, an aversive state of rage, mortification, phobia, enervation, helpless dependency, self-pity, and ineptitude may be clung to with the desperation of a person clinging to his last hold on security. These states are indeed dystonic and aversive, but the patient may regard them as familiar, as an aspect of identity, and as a powerful safeguard against a new experience of hope, disappointment, and failure. The analyst may help by understanding the motivation to cling to the state and, by way of reassurance, remaining with the patient during the state (affect containment). Questioning the “reality” of the aversiveness and deprecating the seriousness of the current context by an interpretation of the past “real” source often is experienced as an empathic failure and confirms the patient’s need for guardedness.

LINEAR AND NONLINEAR ASPECTS OF AFFECTIVE EXPERIENCE DURING THE CLINICAL EXCHANGE

Thus far we have described discrete affects, moods, and states as following a linear mode of action leading to reaction: The analyst fails to remember something the patient has said. The patient feels hurt and angry. The analyst acknowledges the failing and the reaction it triggered. The patient’s affectionate-trusting feeling is restored. Or the patient brings up an event of which he or she is ashamed. The analyst, ostensibly to encourage the patient’s recognition of a pattern of such events, notes several instances, including those in the clinical exchange. The patient experiences this as being immersed in shame and feels mortified. He or she can hear nothing of the analyst’s intent and derives, for the moment, no understanding—only misery from which the patient wishes to escape. The analyst’s recognition of the disruption and acknowledgment of his or her part in it may limit the intensity of the shame-state response. Nonetheless the patient may become avoidant and secretive for days, during which the analyst’s consistent presence helps the mortification to abate. These linear descriptions of disruption–restoration sequences provide excellent guides for analysts to understand common treatment experiences. They fail to do justice either to qualities of affective experience or to the subtle moment-to-moment dyadic affective communication (Beebe, Jaffe, and Lachmann, 1992) that takes place between partners who have an established familiarity (analyst–analysand, caregiver–child, wife–husband). “Mother and infant jointly construct the rules of negotiating social relatedness. These rules guide the management of attention, turn taking, participating in discourse and affect sharing” (p. 73). As the later dyad of married couples and analyst–analysand become established, each partner begins to anticipate and predict the other’s feelings, thoughts, and conversational gambits. This leads to the familiar sense of “finishing” each other’s sentences almost as soon as they begin.

Thus far we have spoken of affective experiences as discrete entities to which each culture gives a linguistic descriptor. Each affective experience involves a feeling, a physiognomic expression, and often an autonomic nervous system reaction. Affective experiences do not simply turn on and off like a lightbulb, they have qualities that Stern (1985) has described as crescendo and decrescendo, surge and fade, bursting and fleeting, explosive and drawn out. These qualities add to the vitalization of overall self-experience that is coincident with emotion, that is, the rise and fall of emotions creates a sense of liveliness when needed or soothing and calming when needed. The result is a sense of aliveness and cohesion of the self.

Stern made another finding that provides an important corollary to the clinical situation. When caretakers were attuned to the activity of babies, the babies, while seemingly unaware, responded by an augmentation of their emotion. In psychoanalysis, when patients experience the analyst’s empathic perceptiveness and often his or her attunement as well, the sense of liveliness, both personal, and in the shared exploratory goal, is enhanced. The recreation of this experience of vitalization and cohesion—what we have referred to as a self/object experience (Lichtenberg, Lachmann, and Fosshage, 1992)—then becomes itself a goal for both patient and analyst. For example, during a period in the middle phase of her analysis, Nancy had been reluctant, because of shame, to experience and express her affection for the analyst. As she struggled with her feelings, that is, with a fuller recognition of both the shame and the affection, the hours had a subdued, draggy quality with Nancy achieving a degree of
vitality by shifting the topic to areas of work and her studies. Then in a series of hours she and the analyst were able to interpret a dream and construct a model scene involving present and earlier expectations that she would be regarded as a foolish girl having a crush on a man who was too aloof or deadened even to notice her growing fondness. As she experienced and expressed her humiliation at the anticipated rejection, her voice became animated, her suffering palpable, and the analyst's responses took on a quickening responsiveness to acknowledge and confirm the intensity (the surging nature) of her feelings. Defiantly she exclaimed she would once again risk feeling her love and appreciation for the analyst, adding her rage at him for his unavailability. In this series of hours, the openness to her feelings, the shift from burst to fade, from explosive defiance to a more drawn-out expression of affection, gave to both Nancy and the analyst a sense of individual and shared vitality.

Patients who can experience more fully their affects and moods, both positive and negative, gain a sense of self-authenticity, of being in touch with their needs, wishes, and desires and thereby gain an enhanced cohesion. Analysts who are empathically perceiving their patient's affective fullness, their crescendos and decrescendos, gain a sense of intersubjective involvement and participation in a vitalized and vitalizing experience and thereby an enhanced cohesion. The analyst's task in successfully helping patients to expand their awareness and expression of positive and negative emotions within the discrete affect and mood range involves sensitive listening and a level of involvement relatively easy to enter into and draw away from, a moment of attentunement and a moment of more conceptual awareness.

One person's attentunement to another's affect is never exact. Mothers can capture babies' rhythmical affect responses, slightly speeding up or slowing down the pace and flow in keeping with an intuitive perception of their mutual needs. Careful observation of analyst responses during successful moments of empathic perceptiveness may reveal that the analyst's verbal tone and physical activity approximate the patient's surge and fade. Careful observation also may reveal the analyst's using a slightly calming tone for an excited patient or a slightly more animated tone as intuitive encouragement to a subdued patient.

THE ANALYST'S WALKING AN AFFECTIVE-COGNITIVE TIGHTROPE: AFFECTIVE EXPERIENCES AS TRIGGERS FOR ROLE ENACTMENTS

In addition to providing an opportunity for attentunement, each discrete affect and mood exerts an evocative power on the analyst to engage the patient more directly—for example, to respond to anger with anger, or to react to haughtiness or envy with criticism, or to sadness with sympathy. The possible responses by anyone to the emotions of another are many. As the patient consciously and unconsciously pulls one way, the analyst by hisown immediate or characterological proclivities may go along with the patient's thrust or pull in one of many other possible directions. In comparison to the relative ease with which analysts can remain empathic attuned listeners to their patients' emerging discrete affects and moods, intense affect states press the analyst toward greater involvement. Often the involvement may take the form of a specific affective and role response that the patient expects the analyst to enact. The enraptured patient does not want the analyst to intervene to help him modulate his or her affection or recognize the illusions he or she has built up; rather the patient in a state of enrapture demands the analyst's participation in the experience, either as the loved one—the object of the rapturous attachment—or as promotor, encourager, co-believer in the goal, if the beloved is another. The pull on the analyst is for involvement, not for listening and interpreting: be it, do it, react, confess, admit, oppose; in short, to up the intensity and join the state somehow, some way. The patient's view of how to obtain or preserve a sense of vitality or cohesion—however maladaptive or unstable—is to have the analyst respond in a role concordant or complementary to his affective state. In the face of the pressure of the patient's expectation, the analyst is required to perform a difficult emotional balancing act, to walk an affective-cognitive tightrope. The analyst must be sufficiently emotionally involved to experience whatever concordant or complementary response the enactment pressure evokes—anger, indignation, sympathy, jealousy, boredom, sexual arousal, sleepiness, and so on (Racker, 1968).

On occasion the analyst may react with an immediacy that surprises both participants. A patient who had been emotionally abused as a child reported picking his son up and shaking him in a terrifying manner whenever his son's provocations got to him. For a long time the analyst had struggled with his impatience and frustration as the patient's intense shame and guilt triggered the patient's immediate plunges into first pseudo-deafness and then sleep, which made it impossible to even discuss the episodes. Then, after much understanding of his aversion to considering his abusiveness, he began to acknowledge and work with the issues—going back and forth between his own childhood abuse at the hands of his parents and his current rage outbursts. For him, shaking his son was like shaking the slats on his crib in desperation to get his sleeping depressed mother to
come. As the last hour of the week was nearing an end, the analyst was ruminating to himself that although he found the patient to be an essentially caring and well-meaning person he had difficulty feeling friendly toward him at times. The patient, in a rarely expressed state of desperation, said to the analyst, addressing him directly by his name, “But what am I to do?” The analyst, without any reflective thought, responded, with a mixture of annoyance, authoritative directness, and pleading: “Be his friend.” The hour ended with the somewhat stunned patient standing and looking at the equally stunned analyst and saying, “Oh, that’s what I should do. Be his friend.” This phrase became the motif for associations for months.

In this instance, the analyst was both emotionally involved with the patient’s frustration-rage and with the patient as an “abused child.” The abused child was both the patient and the patient’s son. Two model scenes organized the configurations of the transference-countertransference enactments that were taking place in the sessions. One drew on the experience of the abused child in the crib desperately trying to get his mother’s attention. The other was of the organically hard-of-hearing father’s turning a deaf ear to his son’s plight. The transference repeated the original mother-son and father-son interactions, but the analyst was in the position of being frustrated, discouraged, and/or rageful when the patient first “went deaf” and then fell asleep. That is, the analyst was pulled toward the emotional state of a desperate child who failed to get the attention of a deaf father and a sleeping mother. The shift in the treatment occurred when, after considerable analytic work, the patient could tolerate oscillating between two shame-guilt states, that of being an intolerant abuser and a helpless, abandoned, abused child. A shift in the patient’s state from being “deaf” and asleep (like his parents) to frustrated and abused (as he felt as a child) enabled the analyst to connect with the patient as an abused child. The shift occurred because the patient could now tolerate the recollections of being frustrated, rageful, and despondent both as victim and victimizer. Previously, on those occasions when the patient had fled into deafness and sleep, the analyst had been left to cope with painful experiences of frustration and disappointment in his effort to move the analysis forward through exploration or even reflective consideration of what was happening. The only goal possible for both was to be soothed back into an awake state of contact.

By asking the question, “What am I to do?” the patient indicated not only a restoration of contract but a shift from helpless despondency to a belief something could be done. The analyst’s response, “Be his friend,” reflected the analyst’s recognition that, based on his own positive connection to the patient, the patient was a person capable of friendly attachment, rather than being limited to victim-victimizer exchanges.

In asking the question, the patient had transcended his pessimistic conviction that he was doomed to experience one side or the other of the aversive relationship with his unavailable, unreflective parents and could acknowledge and tolerate his shame, abuse, and frustration. The analyst’s spontaneous response reflected what the abused child-patient needed from his parents, what the patient’s son needed from his father, but most important, the friendliness the “struggling” analyst felt was possible for the patient and himself (as well as the patient’s son) after the success they were now having following many discouraging disrupted clinical exchanges.

In other instances, the analyst’s response to a patient’s intense affective state may be intense but contained. A very distressed young woman in the early months of treatment was crying hysterically about an incident that, while minor, was obviously very distressing to her. The analyst, to his consternation, found himself suppressing a sadistic giggle. Associating to his affect, the analyst remembered that the patient had mentioned often being provoked and teased by her family. The analyst also recalled participating with others in the cruel teasing of a female classmate and his regret on hearing later that the young woman had had an emotional illness. The analyst regained his composure and made comments appropriately sensitive to the patient’s distress, to which the patient showed little response. As the hour drew to a close, the patient expressed doubts about the treatment at the same time that the analyst was wondering when this slowly developing treatment might get some momentum. The analyst acknowledged the patient’s doubts, said he too wondered about possible sources of problems between them, and wondered if she had any feel for what might be interfering. After a moment’s hesitation, she stated she thought the problem was her fear of ridicule. The analyst felt how energized their emotional responsiveness had been in the form of an enacted complementary dyadic communication of sadistic ridiculing and provocative victim. The analyst consequently experienced a sense of optimism about their ability to respond to and with each other and bring about a successful treatment. The next series of hours were spent exploring her fear of ridicule in both her current and past experiences, with a resulting increase in openness of emotional expression during the sessions.
Both examples demonstrate the analyst's openness to spontaneous role responsiveness and affective expression. Each response by the analyst helped move the treatment forward, each in a different way. The inward sadistic giggle provided information to the analyst of a complementary affective response, helping him to identify a bit of prior lived experience of the patient and himself that was being recreated at that moment. The analyst confined his response to his internal dialogue. In his judgment, the working alliance and sharing of information was not yet ready.

The situation with the male patient was quite different. Patient and analyst had worked together for a long time and had shared extensive information. Despite the breakdown of openness to one another that characterized the moments of blockage to the patient's self-reflection, the ground for a successful intervention was prepared by many experiences of jointly expanding awareness. In one sense this background made the analyst's spontaneity possible and "safe", in another sense the background of frustration and concern for the patient, his son, and the analyst's own sense of efficacy made the affect state of distress and impasse unbearable. A sense of necessity gave impetus to a disciplined spontaneous engagement, but the successful outcome was prepared for by the solidarity of the intersubjective affective connection in which the exchanges occurred.

Affective states that propel patient and analyst toward action rather than exploration are apt to occur under some predictable circumstances. In Chapter 6 we present an example from Nancy's analysis in which the analyst's outrage at Nancy's passivity and rationalizations in response to insulting treatment by her aunt pulled the analyst into an enactment. The analyst stated the patient's claim for better treatment rather than analyzing her failure. In this instance, the effect was to confirm her right to expect more from her family members. It was not experienced as abuse or an encouragement to dependency on the analyst, but we must recognize that when we sway into an interaction the outcome is not predictable. But whatever the reaction is, it can furnish material for further exploration.

Some affective states may develop insidiously, building up when themes, motives, and feelings are either unrecognized or their significance unacknowledged. At other times, an affective state may be triggered by a crisis in the life of either patient or analyst, such as a divorce, an illness (Schwartz and Silver, 1990), the loss of a job or expected promotion, death, or loss of a pregnancy (Lazar, 1990; Gerson, 1994). One group of patients often diagnosed as borderline, especially those who have suffered profound trauma at any time in life, may be unable to tolerate an illusory space without loss of a sense of authenticity in the clinical exchanges. These patients may demand that the analyst react more directly to their unbearable, extremity absorbing affective states. A central feature of affective states is that whatever their origin (analysts' failure to recognize patients' affective needs or their own, crisis-driven altered self-states, or the requirement of a severe pathologic transference expectation), the impact will be experienced in the intersubjective realm as a pressure for more intensified direct reactions. The ordinary stances of analyst to patient and patient to analyst will be more difficult to maintain, and increased self-revelation on both their parts is more apt to occur. In a treatment that has been well established and in which exploratory-assertive motives have been dominant at moments, interactions and revelations of self often may prove beneficial.

In walking the tightrope, we can expect the analyst to sway in the direction of varying degrees of direct emotional involvement without falling off. We know at times this sway takes the analyst beyond feeling to such actions as forgetting appointments, scheduling two patients, making errors on bills, and the like. While action responses of this sort inevitably cloud the intersubjective realm of the treatment, the origin of the particular action may or may not be specific to the analyst's attitudes and feelings about the specific patient involved. It may be in response to the analyst's feelings about his practice as a whole, his financial state, or some other temporary distracting aversion. In any case, to recover his balance the analyst needs to wonder what affect state he has failed to recognize and experience more directly. When it bears directly on the clinical exchange with the patient, the analyst needs to discern through the empathic mode of perception (extrapolation and introspection) signs of an unrecognized triggering pull for a response such as sympathy, sexual arousal, attack, or tuning out and exclusion. Falling off the tightrope occurs in an obvious form when actions the analyst resorts to lie outside professionally acceptable behavior, and in less obvious forms when the analyst cannot restore an empathic mode of perception first with himself and then with the patient. Another danger lies in the analyst's making an unexamined assumption that whatever he feels or does reflects solely a direct involvement in a role or trap the patient has consciously or unconsciously set for him.

The sway to the other side of the tightrope has the analyst restricting his own affective involvement to remain as close to the neutral line as possible. He becomes the silent, distant, cold, "ungratifying" analyst so often caricatured as the "classical" analyst of the 50s and 60s that
Stone (1961) decried. Though the arguments often centered on correct or incorrect interpretations of what was intended by neutrality and abstinence, the main result of the failures of the period lay in the crimped affective engagement that could be created between patient and analyst. Arguments about whether patients required optimal frustration to be motivated or optimal attentunement to fall deficits missed the point that an exploratory-assertive motivational system is always potentially available to explore intersubjective experiences—but an analyst’s stiffness and rigidity may preclude the needed affective engagement from developing. The sway on the tightrope to an affectively impoverished clinical exchange may be so subtle that only after the fall—an interruption or a bland, meaningless termination—can it be recognized.

AFFECTIVE EXPERIENCES CHARACTERISTIC OF THE FIVE MOTIVATIONAL SYSTEMS

Thus far we have taken a phenomenological approach to discrete affects, moods, and affect states, and to how we work with ours and the patient’s during treatment. We have used nine sets of opposites as examples. Obviously, the list could be many times larger. What are the limitations of the model we have used of affective experiences above and below a neutral line? To make this inquiry we return to the five motivational systems.

The principal affective experience in the attachment system is the sense of intimacy. This feeling arises in both the dyadic relationship with mother and father (and any other frequently available person or pet) and, in more complex forms, in triadic relationships where shifting desires and rivalry enliven the intimacy. Thus, affection, trust, love, contentment, generosity, pride, respect, courage, optimism, and moral goodness would all be affective experiences that arise in the course of positive attachment experiences. Likewise, to the sugar of these feelings, the spice of moments of anger, doubt, envy, jealousy, fear, shame, and guilt intensify an attachment experience. Feelings of efficacy and competence are central to the exploratory-assertive motivational system. The whole group of negative affects, moods, and states are experiences that reflect dominance of the aversive motivational system in either separate or combined forms of antagonism and withdrawal. Being energetic and self-assured is more reflective of the state of the self than of any of the systems.

The affective experiences associated with the systems based on the need for the regulation of physiological requirements and the need for sensual enjoyment and sexual excitement differ in some ways from the patterns (Figures 1, 2, and 3) we have presented. The affective experiences in these two systems involve to a much greater degree bodily derived sensations in patterns that bear the stamp of the rhythms of bodily needs and hormonal tensions.

We have described (Lichtenberg, 1989) physiological requirements that come under psychic regulation throughout life: nutrient intake, elimination, breathing, tactile and propioceptive stimulation, thermal control, equilibrium, sleep, and general physical health. We distinguish these physiological requirements and the psychic regulation they require from those silent bodily occurrences such as the function of the spleen, liver, and so on, which are not open to awareness. We have suggested a basic innate schema for feeding is: a need for nutrient intake → the sensation of hunger building to an affect of distress (crying) → sucking and intake experience (variably rapid diminished distress = relief) → a sense of enjoyment and a sensation of satiety (with a state change to another motivational need). The success of the psychic regulation of this pattern is measured by the infant’s achieving a recognition of the existence of hunger and satiety as self-identifiable sensation-affects. Self-recognition of hunger and satiety is only achieved as an outgrowth of sensitive dyadic communication between caregiver and infant with the caregiver picking up the signals of the infant’s rhythms. In clinical work with many adults we neither can nor need to pick up the subtlety of these formative dyadic exchanges. The pattern of hunger-eating–relief and satiety, when well established, needs little exploration. But in the increasingly frequent encounter with eating disorders, eating or not eating, satiety and overeating and vomiting raise a specter of affect disturbances that may or may not harken back to the basic schema having been ill formed (see Lichtenberg et al., 1992, pp. 138–145).

Breathing offers another example of the affect patterns involved in regulation of a physiological requirement. During the clinical encounter, breathing as sensation could be considered as remaining mostly outside the awareness of both partners—in a neutral zone. A possible exception may lie in the breathing qualities that influence the affective-evocative potential of speech. In certain particular situations that occur during treatment, breathing itself comes into direct or indirect awareness. In states of excitement, either pleasurable arousal or fear and anger, breathing accelerates noticeably. In states of diminished arousal, avoidance and suppression of affect, or drowsiness, breathing slows. In situations in which breathing is interfered with during colds, sinus infections, and asthmatic attacks, the
threat of air-passage blockage evokes discomfort with the potential for rapid rise to the panic instantly evoked by a sensation of suffocation. When traumatic experiences involving suffocation have occurred, such as a patient's almost drowning or as in the case of Nancy when Matt would hold his hand over her nose and mouth, memories can recreate the sensation with accompanying panic. Our hypothesis is that during analysis, even when breathing appears to go unnoticed, breathing rates and depth, along with postural changes and stomach gurgles, all enter into the subtle nonreflective dyadic communication. Subliminally attended, these less direct affect-sensation indicators provide a background source of information that adds to the vitalization of the foreground verbal-affective flow, or gives an indication of a flat-devitalized state not obvious from the verbal flow, words without music.

In our view the affect goals of "sexuality" are far more varied than that conceptualized by libido theory. In that theory the model is that of orgasmic discharge—a slowly rising (foreplay) and then more rapidly mounting excitement state (coitus) with orgasmic discharge (pleasure) and a steep decrescendo of sensation with relaxation (satisfaction). Observation of the "sexual" life of infants and adults indicates that two paths are open from approximately nine months on: (1) A need for sensual enjoyment arising as general distress and irritability or a specific sensation in a sensual target zone → soothing, stroking, rhythmic rubbing by self or other → either relief of distress and irritability and specific sensations of pleasure with reduced general tension or (2) Relief of distress and irritability and specific sensations of pleasure with heightened focal and general sensations of sexual excitement. One path involves sensual sensations that can either rise or fall in intensity with enjoyment. One path involves sexual excitement that rises in intensity toward a climax. The path involved in sensual enjoyment may utilize sensations widely distributed across the body—the mouth, skin, anus, as well as the genitals and across sensory modes—sight, sound, taste, and touch. The path involved in sexual excitement may utilize all the other sources of stimulation, but the focus is concentrated on the penis or vulvo-clitoral-perineal area. Sensual enjoyment tends to incorporate feelings of tenderness toward the self or others, whereas sexual excitement tends to incorporate feelings of thrust and power as doer and/or recipient and often a heightening intensification that comes from a sensation of pain. The sensations and affect comprising the total experiences of both sensuality and sexuality may be "autoerotic"
as pattern but not in origin or psychic content. The lived experience of sensuality and sexuality arises from within the intersubjective exchanges of caregivers and infant. Thus, the pre- and postsymbolic representations of these experiences bear the stamp of their dyadic and triadic sources in imagic forms that easily reverse the roles of doer and done-to. The sensual and sexual experiences often include a dreamlike quality of fuzziness and reverie that enhances the interchangeability of subject-object representations. The fluidity of active-passive, masculine-feminine gives these experiences a heightened potential for tapping into multiple domains of dyadic and triadic experience. However, for patients whose self-cohesion is vulnerable, the fluidity of representations is often a source of fear, guardedness against loss of boundaries, and, consequently, intimacy-limiting avoidance (Mitchell, 1993).

The affective patterns that characterize the experiences associated with the psychic regulation of physiological requirements and the sensual-sexual motivational systems are particularly rich sources of metaphorical expression. We conjecture that the crossover from the sensation-rich lived experience of the presymbolic child and later symbolic use of verbal coding affords a particular poignancy to sensation-derived metaphors such as: I could eat you up. Don't be such a tight-ass. You take my breath away. What a nauseating thing to say. You're trying to climb to dizzying heights. Cool down. A red-hot mama. What a poke he's got.

The significance for the clinical exchange of this prevalence of "sensation" language in the metaphors of each motivational system lies in two directions. First, the metaphors orient us to the affectively rich potential of what is being spoken about. Second, the metaphors often enable the patient to make discursive distancing references that may need to be brought nearer to the actual lived experience. A patient may say she was "touched" by what the analyst said, but without expanding the meaning of touched in the specific affective form—she felt affection or felt affirmed or helped to experience the sadness she was suppressing, and so on.

Now that we have completed our survey of affects, affect-sensations, moods, and affect states of each of the motivational systems, we will consider the relationship of affects to each other. In our diagrams, we presented pairs of positive and negative discrete affects, moods, and states as extensions of related emotional experiences. Anger, when not responded to, often will spiral into rage, but an angry person who has been ineffectual in overcoming a frustrating situation can respond by entering a shame state or becoming depressed.
Likewise, an ineffectually angry person can seek calming from overeating and/or sensual seeking. Similarly, an attempt to establish shared affection when not responded to can spiral to a rapturous preoccupation, a state of grandiose indifference to others or rage, depression, abjection, extreme self-pity, anorexia, or obsessive sexual excitement seeking. What can we conclude from this statement of complexity, from the implication that in some circumstance the arrows in the diagram might go from any affect or mood to any positive or negative affect state? Each person has from his or her lived experience propensities for intensification or spiraling to an affect state when any flexible affect is perceived as not having been responded to in a needed or desired manner. We must follow each patient’s communications to track the vicissitudes of all emotions, the sense the patient has of the therapist’s success or failure in understanding and responding, and the potential and pathways for affects to spiral to states. We believe, along with Friedman (1995), that “if an analyst learns to sort affects along several, separate motivational axes, he will very likely develop extra sensitivity to nuances of meaning and feeling” (p. 444).

TECHNIQUES THAT CONTRIBUTE TO FEELINGS OF SAFETY

What technical approaches enable analysands to feel safe enough both to recreate affect states that represent important lived experiences that are necessary to explore, and also to prevent the states from becoming entrenched barriers to reflective awareness? The empathic mode of perception is key. As the analyst succeeds in recognizing the analysand’s affects and moods and in understanding the motivations involved, affects tend to remain flexible, expanding awareness develops, and a sense of safety is established. In Friedman’s (1995) words, “love or the illusion of love is shown when someone supports a person’s subjectively felt thrust” (p. 446). When the analyst inevitably fails in recognizing an affect or mood, and/or the motivation present from the patient’s point of view, an affect state triggered by the failure often will follow. A characteristic of many such failures is patients’ perception of themselves as being treated as an “object,” their subjectivity ignored or overlooked (objectification, Broucek, 1991). As patient and analyst live with (contain) the affect state and begin to explore its triggering by the empathic failure, the patient will have opportunities to correct the analyst’s perception of the source of the disruptive state change. By his or her openness to the

Affective Experience

analysand’s perceptions, the analyst affirms the analysand’s capacity to make reflective observations and to exert influence. This self-assertion helps to lessen the asymmetry of patient and “expert” and itself triggers affects of efficacy and competence, a counterbalance to the disruptive state. Often an additional factor may be present. The patient may identify the analyst’s role in the disruption as the patient perceives (Hoffman, 1983) him or her to be and often this attribution is made in affect-state terms: “You get silent and nurse your hurt feelings when I don’t accept an hour you offer me.” Or “You talk like you know everything and I know nothing.” Or, “You’re too confident that you are attractive to understand how I feel.” These attributions of hurt withdrawal, omniscience, and self-perfection provide opportunities to explore the impact of one person’s state on another if the analyst allows herself to “wear” the attribution. By being open to the premise and allowing oneself to sense into the state, sometimes recognizing a dimly perceived aspect of the self that has been influential in the intersubjective realm, the analyst can model a willingness to explore the impact of an affect state as it inevitably influences a dyadic relationship.