No Place to Hide: Affectivity, the Unconscious, and the Development of Relational Techniques*

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For the past fifteen years, the analytic literature has been dominated by the intersubjective, interpersonal, and relational approaches. Reacting to the reign of positivistic, authoritarian, ill-conceived notions of the analyst as all-knowing, perfectly analyzed, and neutral, what has become known as the one-person perspective has been effectively set aside as a viable model. Or has it? While most people seem to agree with the basic relational and intersubjective approaches outlined by Aron, Benjamin, Ghent, Hirsch, Levenson, Mitchell, Stolorow, and innumerable colleagues, many people have balked at both the theory and potential applications of social construction. The constructivist model began with Hoffman's (1983) classic paper, “The Patient as Interpreter of the Analyst's Experience,” and most clinicians read it with relief. Much of the literature that followed informed clinicians of the subjective nature of the analytic relationship—something they already knew from their own clinical experience.

Finally, all the things we were actually experiencing with patients were being said out loud. We were off the hook for not being perfect. And we were freed from trying to practice in ways that did not work very well. We could stop being authoritarian, rude, and withholding. We could be human beings and analysts at the same time. This trend toward humanizing the analytic process and acknowledging the inherent mutuality seemed unstoppable.

But lately the tide seems to be turning. People who were comfortable with acknowledging the patient as interpreter of the analyst's experience are not so comfortable with the notion of everything that happens in the

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room as mutually cocreated and implicitly unknowable. As the two-person position relies heavily on a philosophical perspective rather than a pragmatic one, some clinicians find their relief turning into confusion, anxiety, and frustration. It seems that once we admitted to our countertransference and the mutuality of the therapeutic relationship, we did not have a clear idea of how it should be handled in the consulting room. Dramatic anecdotal accounts of analysts spilling their innermost feelings, including sexual ones, left many clinicians feeling queasy rather than relieved. Greenberg (2001) has been critical of what he perceives as a personality cult developing within the relational movement, whereby individual analysts portray themselves as magical healers.

The analytic situation has expanded, leaving more room for the individuality of analyst and patient, and more room for the unknown. It seems that we are currently much better at talking about what we cannot know than what we can. As much as most clinicians understand that our countertransference contributes to the patient's mood, thoughts, and responses and feel comforted by the acknowledgment of this interaction, we are unnerved by the thought that nothing is absolutely knowable. We do not like questioning everything we think and feel about the patient. And we certainly do not like going from the position that we know everything to the position that we cannot absolutely know anything. Reluctant to prescribe any new techniques, we failed to translate adequately our theoretical revisions into new clinical practice rooted in theory. Using one's intuition may work for experienced, master clinicians, but how can we teach our approach to young clinicians looking for guidelines and hands-on information?

A View from Our Critics

Many people seem to feel that the two-person pendulum has swung too far, that there is too much emphasis on the analyst's experience and on the here and now. Grotstein (1999) notes that with the ascendance of the two-person approach, “the regard for the unconscious has notably declined” (p. 52). Support for discontent with the two-person approach is distinctly visible in recent issues of Psychoanalytic Dialogues. In the lead article in Volume 9, Number 3, 1999, Jeanne Wolf Bernstein severely criticizes the two-person approach for its emphasis on the dyad, ostensibly not leaving room for the unconscious. She says,
Although the relational school of psychoanalysis has successfully dismantled the antiquated Freudian notion of the neutral analyst and has shown just how personal and human the analytic encounter is and ought to be, I contend that, in doing so, it ignores the third dimension of the unconscious axis in the analytic encounter. [p. 278]

Clearly unimpressed with the recent emphasis on countertransference and mutuality, Bernstein further states:

To what extent can the current infatuation with countertransferentially guided interpretations constitute an elegant disguise for an analyst's narcissistic gratifications? With this new literature on the necessity and efficacy of the analyst's personal involvement, a theoretical leverage is provided that allows psychoanalysts to be preoccupied by and enamored with their own musings by listening more to their internal echoes at the expense of their patients' intrapsychic conflicts. [p. 281]

Here we see the resurfacing of old insults often hurled in the past at interpersonalists. We are found to be self-indulgent and intellectually deficient. Were it not so politically incorrect to say so, would Bernstein have added insufficiently analyzed?

To be sure, the commentaries that followed in the pages of Psychoanalytic Dialogues certainly took issue with Bernstein's position, especially those by Lynne Layton (1999) and Irwin Hirsch (2001). Hirsch decries Bernstein's efforts to label relational or interpersonal analysts as neglecting the unconscious and, for better or worse, says that she is wrong in thinking that deliberate self-disclosure is basic to the two-person approach—an arguable defense at best. Recent discussions of self-disclosure have given way to the criticisms of blatant narcissism by analysts. Hirsch says Bernstein is not alone in this criticism of analysts' self-revelations, even though he adamantly disagrees with her belief that the unconscious has been neglected.

In an additional commentary, Layton notes that the two main concerns of those who take issue with the two-person approach are: (1) “Does the two-person paradigm do away with the unconscious?” and (2) “Has the two-person paradigm's emphasis on countertransference given analysts permission to unleash their narcissism on their unwitting patients?” (pp. 307-308). It seems to me that these points do need to be addressed more thoroughly than they have been. I think it is unfortunate that, in the
course of developing the uncharted territory of the therapeutic relationship, some have taken this to mean that we have abandoned the unconscious. As Hirsch says in his comments, we certainly have not. But apparently we have not done an adequate job of conveying this to our readers and listeners. More importantly, I believe we have barely begun to develop a body of two-person technique that is reliable and teachable. I imagine therapists being inspired by one of the aforementioned dramatic anecdotes by a famous analyst, only to try what seems like the same thing and be met with utter failure.

My own work for the past twelve years has focused on countertransference, self-disclosure, and affective communication and engagement in the analytic relationship, presumably everything that Bernstein thinks has been overemphasized and has led to narcissistic excess in the two-person approach. I do not agree. My argument has consistently been that without building clinical use of the countertransference into analytic technique, our theoretical revolution does not amount to much. Moving from the one-person to two-person theoretical stance necessarily requires us to factor in what is important in terms of the analyst's responses, what is not important or even harmful, and how to execute these techniques favorably for therapeutic benefit. On this point, I'm afraid that our critics have much to crow about. Our reluctance to provide guidelines has left a void, especially for therapists in training. The rationale was a well-intentioned one—the avoidance of dogma and authoritarianism.

Wouldn't new rules only create a new structure that would inevitably become reified and stilted, just as classical analysis had? No doubt. In fact, French philosopher George Simmel (1984) observed that this is the nature of all structure. With institutionalization comes reification. Ultimately, the new structure becomes rigid and unresponsive to current needs. Those who are free enough to be creative then bring it down. Then new structures begin to be built. This loop is endless, just like the process of birth, aging, and death. It is natural and inevitable. It cannot be avoided in the hopes of keeping things constantly new and changing. It is incumbent on us to create an order that our young colleagues will eventually rebel against and dismantle so they can create their own order. Our attempts to stop time by deemphasizing structure and promoting a state of perpetual fluidity and creativity have, instead, created a vacuum that needs to be filled.

I believe that the future of relational analysis depends on our ability to fill this void and answer our critics. We need to address the issue of
self-disclosure more closely and agree on principles and guidelines for self-disclosure, as well as other technical interventions. And we need to incorporate the unconscious not only in our theoretical writings, as Aron (2001), Atwood and Stolorow (1984), Bromberg (1998), Ogden (1989, 1994), D. B. Stern (1997), Stolorow, Brandchaft, and Atwood, (1987), and Stolorow (1988) have done in the course of developing the two-person approach, but also in our clinical discussions. We know that we have not abandoned the unconscious, as the preceding references abundantly illustrate. Yet we do not often discuss how the unconscious fits directly into our here-and-now clinical interventions. Case examples frequently omit specific actions by the therapist or fail to tie them to the theory that has been presented.

The question of “Where is the unconscious?” in modes of analytic treatment that focus so heavily on the manifest content of the session is an intriguing one. Two implications of this question immediately come to mind. One is that analysts working extensively in the present do not step back and make broader interpretations that transcend the immediate moment. The second is that focusing on the present, particularly on affective exchanges between analyst and patient, necessarily bypasses and ignores the importance of the unconscious. My own recent work has centered on the role of affect in making the unconscious conscious.

**Affect and the Development of Psychoanalytic Technique**

Spezzano (1993) has documented the role of affect in psychoanalysis, noting that Freud did little with this topic other than emphasize catharsis. Certainly, the affects of the analyst were not considered to be relevant. Classical analysis was involved in helping the patient to relive affective experiences from the past in the present relationship with the analyst. If an emotional event occurred between analyst and patient in the present, however, the patient was reminded that his immediate experience had its antecedents in the past. While some patients accepted this process as reasonable, many others felt humiliation and rejection when they were quickly dispatched to their childhood. They knew their feelings were real in the present, regardless of the antecedents, and wanted to have these feelings acknowledged in the present relationship with the analyst. Inescapably noting their emotional impact on the analyst, many patients demanded confirmation of what they saw or heard the analyst feeling. I say saw or heard, because we now know that felt emotion registers on...
the face and in the vocal tones of all human beings. Had these realities of affective experience been as widely known fifty years ago, psychoanalytic technique might have developed along a different course. Believing that analysts could be neutral and objective in their responses to patients was like believing that an apple dropped from a first floor window would travel upward. Developmental and affective research has contributed significantly to the recognition of mutuality in the therapeutic relationship.

The evolution in the two-person approach has been a long one, with many false starts. The interpersonalist and object-relations theorists have been working on this model for sixty years. (See Aron, 1996; Greenberg & Mitchell, 1983; Lionells et al., 1995, for historical perspectives on the two-person movement.) The counseling psychology movement in the 1960s and 1970s (Carkhuff, 1969; Rogers, 1961; Truax, 1970; Truax & Carkhuff, 1965) provided research confirming the therapeutic value of empathy and genuineness. Kohut (1971, 1977) highlighted the vital self-affirming role of empathy. Intersubjectivists Atwood and Stolorow (1992) took the work of Kohut and his predecessors a step further by focusing not only on sustained empathic inquiry, but also on the affective exchange between analyst and patient. “We define the stance of sustained empathic inquiry as a method for investigating the principles unconsciously organizing experience” (p. 33). Here we see the reference, italicized for emphasis, to the unconscious. They are clear in saying that encouraging the patient's expression of deep feeling, and responding empathically to that display of feeling, will result in the surfacing of what they refer to as the “unvalidated unconscious”—that which has been repressed in the absence of an empathic validation.

D. B. Stern (1997) speaks eloquently about the patient's unconscious experience, taking issue with the notion that, through repression, material that has previously been known becomes unknown. He describes what he calls “unformulated experience”—that which the patient has dissociated and never articulated. Discussing the work of Schachtel (1959), he says that from his perspective, “psychoanalysis is not a search for the hidden truth about the patient's life, but is the emergence, through curiosity and the acceptance of uncertainty, of constructions that may never have been thought before” (p. 78). Unlike many theorists, Stern also clearly illustrates his approach to facilitating the emergence of unformulated experience with detailed clinical examples.

So we have major theorists who focus on the here and now, yet make it abundantly clear that their goal is not merely to communicate in the present with the patient, but to facilitate the surfacing of unconscious
material. I think most two-person theorists and clinicians would agree with
the notion that any work in the present that fails to stimulate new awareness in
terms of feelings, memories, and buried desires is somehow inauthentic and
not truly responsive to the patient.

While Stolorow and Atwood focus primarily on empathic responding
defined as acknowledging what the patient is feeling, my own work has
focused on the use of self-disclosure to augment the affective responding to
the patient. Building on their work, as well as the work of Tompkins (1962),
Daniel Stern (1985), Krystal (1988), and many others, I have proposed that
the affective responses of caretakers that are so vital to the affective
development of the infant and growing child are equally important in the
therapeutic relationship, where most patients suffer from some degree of
affective stunting. I (Maroda, 1999) refer to the use of affective disclosure on
the therapist's part as essential to completing the cycle of affective
communication, most times begun by the patient, but sometimes by the analyst,
each emoting and responding to each other. I have made the argument that for
the analyst to attempt to stifle her naturally occurring emotional responses is
to deprive the patient of exactly what he is desperately seeking, both to
validate his own emotional responses and to encourage the feeling and naming
of buried affects.

I have also said that self-disclosure, when done at the patient's behest,
either through directly asking the analyst what she is feeling or through
repeated projective identifications, facilitates this affective communication. I
think it safe to say that nowhere is the work of the unconscious more evident
than in projective identification, be it from patient or analyst, or in the mutual
enactment that often accompanies it. The analytic literature is replete with
eamples of projective identification, moving from the old view that the
patient uses it to “dump” unwanted feelings on the analyst and force her to
feel bad, to a more constructive view of projective identification as an
attempt to communicate disavowed affect to the analyst.

The topic of unconscious affect is critical to any discussion of projective
identification. Is there any evidence that affect can be unconscious and, if so,
what are the conditions and manifestations of unconscious affect? Not
surprisingly, we find that consciousness of emotion is a relative concept.
Awareness of emotion is a continuum, with all levels of awareness being
possible. Griffiths (1997) says,

> A process which is perfectly capable of being consciously
> monitored may proceed unconsciously because of an unconscious,
or even a conscious,
decision not to monitor it…. Disclaimed action emotions can therefore be more or less sincere, depending on the extent to which the subject realized that his responses are voluntarily initiated or exaggerated. It is possible to distinguish a whole range of possibilities, such as straightforward pretending, mere inattention to one's motivation, self-deceit, and real deep-seated inability to get at one's motivation. [p. 154]

Other affect research notes that basic emotions, outlined by Darwin and Tomkins, which include sadness, joy, anger, and surprise, are hard-wired and are the easiest to stimulate and repress with the least cognitive processing, and therefore least likely to be experienced consciously (LeDoux, 1995). Izard's (1969) cross-cultural studies confirmed that these emotions are basic to all humans. Feelings that require cognitive processing for their existence, such as shame and love, are more difficult to repress. Predictably, intense feelings are more likely to be conscious than nonintense feelings (Rosenberg & Ekman, 1997). And negative feelings are more likely to be in awareness than positive feelings (presumably because they are hard-wired for protective purposes). Although more research needs to be done in this area, there is some evidence that nonverbal signals other than facial ones, for example, visceral reactions, are also hard-wired. And LeDoux (1994) has postulated that empathic visceral responding also proceeds without conscious awareness or cognitive involvement.

Other empathic responses can also exist out of awareness. Hansen and Hansen (1994), in summarizing the research on facial expression, note that the listener tends to mimic the facial response of the speaker, and subsequently feels the feelings of the speaker. (This fact is encouraging, because the “speaker” in the analytic dyad is, first and foremost, the patient. Again, we see that old analytic wisdom—the patient must begin the session and set the tone—corresponds with affect research.) The term in the affect literature for this process is “automatic reference,” which means that “emotion can be instigated without the intervention of controlled cognition” (p. 236). Thus the listener automatically adapts to the emotional state of the speaker without necessarily being aware that he has done so. Brown (1993) informs us that while affect expression may be innate, the capacity for affect experience unfolds in the course of development. It is learned. Brody and Harrison (1987) tell us that children's abilities to accurately label and express their feelings are highly dependent on their caretakers' having expressed their own feelings. So expression of emotion begets expression of emotion.
When two people are in a room, particularly when they are able to view each other's faces, all experienced affect, conscious and unconscious, will be communicated to the other person. Our lack of awareness of what we are feeling does not mean that it has not been communicated and stored. At some level, we know everything the other person is feeling, even if he or she does not want us to. Complicating things further, not only can affect be unconscious, but social conditioning can result in the individual unconsciously displaying an affect that is the opposite of what he is feeling, provided that there is someone to witness it.

Ekman (1971) showed films to groups of Western and Japanese students and videotaped them without their knowledge. Both groups responded similarly to the films, expressing negative and positive affects at the same points in the film. When the films were shown again with an experimenter in the room, however, the Japanese students' facial behavior differed radically from the Western students', Griffiths (1997) reports this study, describing how the Japanese students' negative affective responses were altered when the experimenter was present.

Slow motion videotape analysis showed the micromomentary occurrence of characteristic negative emotional expressions, and then showed them being replaced with a polite smile. This behavior appears to have been unconscious and relatively automatic on the part of the Japanese. It is presumably inculcated in childhood. The convention that negative emotions are to be masked by smiling in certain social settings represents what Ekman has called a “display rule.” [p. 55]

Display rules can also be idiosyncratic within the family structure, something we have all seen in our patients. One patient cannot show anger, another cannot show happiness, another cannot be sad. Or can they? The display rules explain the quick conversion from one affective state to another, yet the original affect does appear, even if it can only be verified through slow motion videotape. But that means that the person receiving the affective communication is likely to register it. A recent study (Dimberg, Thunberg & Elmehed, 2000) confirms that masked affective displays are recognized by the recipient, but only unconsciously.

The literature on affect to date supports what has simplistically come to be known as the “two-person approach.” Both analyst and patient do communicate with each other constantly through both their choice of words and vocal tone, and through their facial communications and body language. What continues to trouble many analysts is how best to use
this awareness of mutual influence. Now that psychoanalytic theory has changed, and done so in line with the realities of the relationship, how should technique change to accommodate this paradigm shift? Specifically, what can we do in the present that will further the analytic goal of making the unconscious conscious? Taking into consideration the other major criticism of the two-person approach, how can we develop techniques that do not, either in appearance or in reality, encourage self-indulgence and narcissistic displays on the analyst's part?

As I stated previously, a major obstacle to creating such a body of technique comes from within the two-person movement itself. I am frankly frustrated by the seeming lack of interest in this topic. I think we have taken the notion of the uniqueness of every analytic dyad a bit too far, implying that no general principles of human nature and interaction can be applied. We are encouraged to resist making any judgments about, who the patient is and how he or she affects others, even though patients themselves usually talk about these things freely.

For example, a thirty-five-year-old female patient, Sarah, came for treatment because she was not able to establish and maintain relationships with others. Not only did her friends and co-workers inevitably become enraged with her, she often provoked perfect strangers into hostile acts against her. And sometimes she accomplished this without having to say a word. A couple of years into the therapy, Sarah asked me what I thought about her uncanny ability to make people angry. I told her that she had so much hostility stored up from her traumatic childhood that it emanated from her like a magnetic field, even though this happened when she was not aware of feeling angry at all. This, of course, was the most confusing part for her. She would stop at the store on her way home from work, not consciously feeling anything but tired, and manage to enrage the clerk who waited on her.

Being highly intelligent and motivated, Sarah knew she had to be doing something. But what was it? We talked at some length about her emotional memories and affect programs and how she might work to manage and alter them. I also gave her feedback, letting her know whenever I found her specific behavior or attitude to be disrespectful or irritating to me. We would then try to sort this out and identify what was happening between us. Sometimes she accurately pointed to my vulnerabilities, or what I had done to provoke her. Sometimes I took a very confrontive posture, telling Sarah that her attitude toward others was often disdainful and dismissive, as though the only person whose feelings

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were important was her. She reluctantly admitted that this was often true and that she had feelings of entitlement—expecting others to make up to her for her terrible childhood. I told her it was unrealistic and unreasonable to expect that. It would simply never happen.

Sarah was a very willing participant in her emotional reeducation and was particularly fascinated by the concept that she actually had a hostile “aura” that affected everyone with whom she came in contact. I asked her if she could actually feel the hostility coming off her, and she said she could if she focused on it. We then talked about how she could work to modulate or even eliminate that aura—especially when she was not really angry in the present moment. Part of this approach involved encouraging her to be more assertive, so that she was not routinely carrying around unexpressed resentment toward others. She learned to be more assertive when her needs or wants were reasonable and to talk to herself and calm herself down when she was being unreasonable, and she learned how to identify when she was being reasonable and unreasonable. As a result, she became able to sustain positive relationships with co-workers and friends. She even established an intimate relationship and got married, somewhat to our joint amazement.

I think we could benefit from exploring how relational patterns are laid out in the brain as affect programs and what the process is for altering those programs. I also think we could benefit from honestly saying what we think works, and what doesn't, even though this leaves us open to criticism from our colleagues who see things differently. In spite of all our idiosyncrasies, I have confidence that our collective experience can teach us something about how to be better therapists, if we are willing to talk about what we really do.

Rebecca Curtis (2001) recently presented the results of her research, entitled “What 75 Analysts Believed Led Most to Change in Their Own Analyses,” and I found her results both encouraging and fascinating. These analysts listed self-disclosure of the analyst's feelings as a major positive behavior leading to change, along with being engaging, sharing power and control, and establishing a warm, empathic relationship. Interestingly, advice was valued positively if the analysand had asked for it, negatively if he or she had not. Being an advocate for self-disclosure, at the patient's behest, I am encouraged by this research.

Even though self-disclosure has become more accepted in recent years, my colleagues who support the notion of greater openness and self-disclosure with patients often disagree with my guidelines emphasizing the self-disclosure of affect, rather than personal information or the
analyst's fantasies. I agree that sometimes information or fantasies can be helpful, but usually only if they stimulate some deep feeling in the patient that resonates with his current emotional state. Most analysts who favor self-disclosure do so in an anecdotal way, and often disagree with my focus, which emphasizes the self-disclosure of affect as the essential therapeutic action. Their intuitive approach cannot be taught to new therapists because it relies heavily on extensive clinical experience. Focusing intently, however, on the patient's affective state, vocal tone, facial expression, or stomach rumblings, as well as one's own, can be taught. Constructive expressions of the analyst's affective response, and the timing of those responses, also can be taught. As much as we might like to think that listening to the patient's words will tell us everything, there is abundant evidence that this is not true.

The more we discover about the human mind and early experience, especially trauma, the more we know that emotional states can be buried in the unconscious, waiting to be reawakened by some stimulus in the present. As much as psychoanalysis has focused on recall of past events, we now know that much of what is important in an individual's life are feelings that are often not anchored in memory of an event, either consciously or unconsciously. Rather, the emotions are encoded. LeDoux (1995) says, early memories may be emotional memories (and not explicit, declarative conscious memories) because the emotional memory system (and not the declarative system) is functional at the time. Second, early emotional memories, including traumatic as well as nontraumatic memories, may be inaccessible to consciousness not because of active repression but because of the time course of brain maturation. Third, the extent to which one can gain conscious access to these early memories, which were encoded in the absence of the conscious or declarative memory system, may be limited. [p. 230]

Perhaps this is why we often struggle so to understand why a patient feels the way he does, in the absence of any recoverable memory to account for it. (This research relates nicely to D. B. Stern's aforementioned notion of “unformulated experience,” but also suggests that, in some instances, the patient may never succeed in articulating this experience.)

Other cognitive principles, such as the need for closure, push us to fill in the blanks, to find an explanation. And this may account for the many
elaborate memories that therapist and patient have created together, sometimes falsely, to account for the symptoms of trauma. It is unfortunate that what started out as the therapist's and patient's genuine need to know and understand sometimes resulted in the production of false memories.

How We Change

LeDoux goes on to point out that emotional memories mediated by the amygdala are indelible and can only be modified over time through inhibition rather than extinction. This occurs concurrently with the experience of new emotional responses, which can eventually dominate and inhibit the old responses. This is how we both change yet remain the same. An appropriate goal for analysis, particularly as it relates to addressing these early emotional memories, is to allow them to surface and be dealt with for what they are: pure feeling states, with little or no recall of events. This means that at times we must give up our desire for intellectual knowledge and awareness of early experiences and settle, instead, for allowing repressed affect to become conscious.

Cognitive behaviorists understand the need to create new associations and new synaptic links, done most deeply through systematic desensitization and most superficially through altering cognition. Armed with the knowledge that any affect can be reduced or amplified by cognitive mediation, cognitive therapists teach their patients to reduce the intensity of disruptive feelings through changing cognition. I think we have to acknowledge that the world has embraced this type of therapy because of its short-term efficacy and because it deals head-on with the pervasive problem of affect regulation in the patient population—something that, in my opinion, psychoanalysis has failed to do. Our standard response to our patients' affective displays centers on "containing" them, which at its best consists of a quiet, empathic acceptance, and at its worst consists of sitting and doing virtually nothing while the patient explodes in an affective storm.

The analytic literature regularly displays the conflict that exists between our desire to acknowledge the importance of mutually created affective exchanges between analyst and patient, and our fear of undue influence and derailing of the treatment. We naturally wish to avoid contaminating the patient's experience with excessive intrusions by the analyst. Yet there are many times when neither interpretation nor empathy
succeed in the difficult task of communicating with a patient who is in the throes of deep, primitive feelings. McDougall (1978), in her discussion of primitive patients, says, “Rather than seeking to communicate moods, ideas, and free associations, the patient seems to aim at making the analyst feel something, or stimulating him to do something: this ‘something’ is incapable of being named and the patient himself is totally unaware of this aim” (p. 179).

I believe at these times the patient McDougall describes is seeking a personal affective response from the analyst. Since the patient's feelings are unconscious, no amount of scrutiny at a verbal level will reveal the nature of the patient's need. And even if the patient knew what he needed at an affective level, this in no way would ameliorate the need for an affective response from the analyst. At such moments, the patient literally feels tortured by the analyst's persistent inquiry. And the analyst typically feels frustrated, thwarted, and helpless to respond in any meaningful way. The literature is replete with case examples where the analyst persists in seeking the correct verbal response for what is essentially an affective event. Words can only be useful if there is emotion behind them. And the sense of failure when analysts talk about working at an affective level is palpable. My patient Sarah often stimulated anger in me, as she did in everyone else, and nothing short of a display of anger from me ever had any impact on her in those emotional moments.

Our preoccupation with our failures in the affective domain extends to the literature on projective identification and enactment, phenomena that can threaten to overcome the analyst with intense, primitive affect. In the past we shamefully blamed the patient for our strong, unexplained emotional responses, not recognizing that the patient was communicating split-off affect to us so that we could know about it and help him or her to accept and manage it. I have stated previously (Maroda, 1991, 1999) that patients up the ante when their projective identifications go ignored or are simply contained by the analyst. They want, and need, an emotional response and will typically keep stimulating the analyst until they get one.

Enactment, on the other hand, remains somewhat of a mystery, but I believe it consists of unconscious emotional scenarios, mutually tapped into by analyst and patient, culminating in some behavior that is egodystonic for the analyst (Maroda, 1998a). In other words, I think that enactment is as much about the analyst's past and repression of affect as it is the patient's. I believe that we perseverate on these deep primitive
affective events in psychoanalysis, in part because they are unconscious-to-unconscious communications that both disturb and intrigue us, and also because we seemingly cannot accept that we cannot make use of these experiences through interpretation or some other type of intellectualization.

We underrate our emotional responses to our patients, in their pure form, struggling to find words where none exist. But this flies in the face of the aforementioned research, demonstrating that infants and children need affective responses from others in their environment to achieve affect management. And it is likely that adults do, too. It also ignores the reality that we think better when something stimulates our feelings as well as our intellect (Niedenthal & Kitayama, 1994; Panskepp, 1994). Granted, the best interpretations also accomplish this. But in our daily work with patients, how often do we make an interpretation that unleashes a flood of feeling and opens up the patient's understanding of where that feeling originated? But we often have strong feelings in response to our patients. I believe that these moments of strong feeling offer great opportunities for therapeutic change. For those who still believe that our strong emotions are a hindrance to the analytic enterprise, there remains a natural tendency to mask these feelings.

As Freud (1913) said, regarding his use of the couch, “I do not wish my expressions of face to give the patient material for interpretations or to influence him in what he tells me” (p. 134). Interestingly, Freud's first concern is that the patient will know him too well. He does not want the patient making interpretations about him. Secondarily, he does not want his emotional response to influence the patient. I think that those of us who have embraced the two-person approach still struggle with the knowledge that hiding our emotions is antitherapeutic, yet do not know clearly how and when any overt displays or verbal disclosures of feeling will be most helpful. As the studies cited here clearly demonstrate, any attempt to hide what we are feeling actually forces the patient into new acts of repression, rather than raising his or her awareness. So if one of our goals is to truly make the unconscious conscious, then we need to show some emotion. But we are still left with how to accomplish this in the patient's best interest.

I believe that any verbalization of felt emotion should be at the patient's behest, either through directly asking or noting what the analyst is feeling, or through repeated projective identifications, which turn into

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impasses when the analyst withholds her honest emotional response. More needs to be said about how actually to identify these situations with reasonable accuracy and also how to disclose constructively, issues I addressed in some detail in *The Power of Countertransference* (1991).

Needless to say, none of the advice I give therapists regarding self-disclosure includes simply expressing any strong feeling the therapist is having. The whole point is that it is done sparingly and in response to the patient's need to know. But I do encourage analysts not to attempt to disguise any feeling they are having, because this forces the patient to record this information unconsciously and is thus countertherapeutic. Once the patient has witnessed the analyst's affective expression, he is free to comment on it or ignore it, as he chooses. Approaching self-disclosure this way keeps the focus on the patient's need, rather than the analyst's, including the critical issue of timing.

I make a practice of not disguising my affect to my patients, particularly as it relates to them. Having practiced this way for the past twelve years, I have noticed that my patients do not ask me to verbalize my feelings as much as they did in the past. I believe they do not need to ask as often because they already know. And I have also found that my facial expressions or voice tone are not as likely to be intrusive as a verbalization of feeling can be. The patient is free to note what I am feeling, or not to note it, as he wishes. Very often the patient goes on talking even if my eyes are filled with tears, or he may begin to cry. Affective communication does not require words, either in the sending or the receiving, and therefore can be accomplished without impinging on the patient's narrative flow and without the risks of overstimulation that can result from a verbal self-disclosure.

But this silent form of affective disclosure is not always sufficient for patients who are in the midst of a projective identification or who are emotionally out of control within the session. These patients need a strong response from the analyst, which often includes limit-setting. I have often spoken of the tendency for borderline patients to stimulate hate in the analyst while they are claiming to feel love. Often the analyst or therapist feels guilt or even shame about not loving the difficult patient who is in great pain, as Ferenczi felt with R. N. (see Maroda, 1998b). And, just as often, the analyst, as Ferenczi did, may placate a demanding patient in the interests of not only avoiding conflict, but also in the interests of denying these unacceptable feelings of anger or hatred in the analyst.
Again, I think more can be done to help therapists early in their training to accept even the most difficult feelings, such as sadistic impulses, strong erotic responses, envy, hatred, and deep love, with equanimity and a certain amount of healthy curiosity. How many therapists learned in their training that patients who have been molested will be seductive, because this is the relational pattern they learned at an early age, and that it will be natural to have sexual feelings toward these patients and even sexual dreams and fantasies? How many young therapists were taught that these same patients may come to their sessions dressed in an inappropriately revealing manner, or may adopt seductive poses or touch themselves during sessions, and that these behaviors should be addressed by the therapist? How many therapists were taught that people who were sadistically abused as children will sadistically abuse the analyst, or encourage the analyst to sadistically abuse them, or both? The list could go on and on. Acknowledging the inevitability of these situations frees the therapist from much guilt and shame over the resulting emotions. Teaching appropriate interventions, while encouraging the therapist to find a way to express himself within his own personal style and his knowledge of what works with a particular patient, is not only possible but also necessary. I find that many therapists are reluctant to stop a patient from being verbally abusive, believing instead that their role is to be tolerant and to perform a containing function rather than setting limits. Discussions of how and when to set limits, with reasonable guidelines, is yet another body of technique that can be taught.

In The Power of Countertransference (1991) I outline when and how to self-disclose, how to identify signs of countertransference interference or dominance in the treatment, how to deal with feelings of loss, envy, abandonment, and disappointment at termination, and other technical issues. In Seduction, Surrender, and Transformation (1999) I expand this work to include a discussion of why self-disclosure can work even if the analyst is in the throes of his own pathology, how affect is at the heart not only of attachment, but of all intrapsychic and interpersonal functioning, how affect theory supports the relational model, how physical, contact can be used therapeutically, and how the analyst can uphold or fail to uphold her legitimate authority in the treatment through specific behaviors and attitudes.

More recently I have come to believe that face-to-face therapy works better with most patients, simply because the face is where all affect is primarily registered. If the analyst and patient cannot see each other's
faces, they are both losing a wealth of information and opportunity for communication.

Suffice it to say that I am committed not only to the notion of affect at the core of the therapeutic experience, but also to continuing to develop specific techniques for optimizing the therapeutic experience. I do so, of course, with the knowledge that any technique is only as good as the person who is using it. Grounding technique in both affect theory and existing psychoanalytic theory reveals that there is much to do to improve our grasp of it, and I believe, as do many others, that it is time to take on this challenge. Younger therapists, in particular, who may admire the relational, interpersonal, and intersubjective models, yet have no idea how to implement them, look to us to provide more than anecdotes and philosophy. If the two-person approach is to survive and continue to influence new generations of therapists, we must empower clinicians with techniques that are solidly grounded in theory and research. We must give them techniques they can master and that work.

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