LOUIS W. SANDER AND THE QUESTION
OF AFFECTIVE PRESENCE

GERALD STECHLER
Boston University School of Medicine

REMINISCENCE AND TRIBUTE

"Can you feel known if you do not know the knower?"

My aim in this article is to tell of the profound influence Lou Sander has had on my life and work, and to tie it to a particular technical and philosophical issue that currently occupies me as a psychoanalyst and psychoanalytic therapist dealing with individuals, couples, and families. That issue concerns the affective presence of the analyst/therapist in the session.

From the time we first started working together in 1954 at the Child Development Unit of the Department of Child Psychiatry at Boston University School of Medicine, Lou has been a guiding light to me, an inspiration, a stabilizer, and a beloved companion. He has also been the gentlest challenger one could possibly hope to have to validate and sharpen one's thinking.

Among our many points of connection was commiserating with one another about our analyses. I was in a training analysis, while Lou, an advanced candidate, was working with a new analyst due to the illness, and then death, of his first one. Both of us were perplexed and often pained by the stringent neutrality of our analysts. "Neutrality" did not feel very neutral to either of us, in part because the theory and practice of analysis at that time veered so much in the direction of judgment. We joked about the two rules of training analysis, "Say whatever comes into your mind," and "Whatever you say will be held against you." The pain we felt revolved around a feeling which later became a centerpiece in Lou's thinking, that is, the feeling of not being known. One feels somehow misread by his analyst, and the attempts to establish a close connection are deemed defensive or seductive.

Our longitudinal research on early child development led us to create a revisionist viewpoint of psychoanalysis. Lou was deeply moved by the intimate details of the moment-by-moment interactional engagement between mother and infant. The sense of mutual shaping and regulation emerged for him as the dominant motif through which to understand and simplify the overwhelming complexity of the data we were gathering. His reading took him outside of psychoanalysis to the biological general systems theorists and to the evolutionary ethologists who provided the only relevant model for the material we were observing.

His genius came from his conviction that there was an underlying order to the combination of the powerful unfolding of the infant's developmental timetables and the idiosyncratic interactional modes introduced by the mother's constructions of the baby's being. He knew that

This work was supported by the Jack Spivack Child Development Fund, Boston University School of Medicine.
Address correspondence to: Gerald Stechler, Ph.D., 21-A Muzzy Street, Lexington, MA 02421.

INFANT MENTAL HEALTH JOURNAL, Vol. 21(1-2), 75-84 (2000)
© 2000 Michigan Association for Infant Mental Health
the answers did not exist in the available literature, and had to resist the internal and external pressures to shoehorn all the material into the existing psychoanalytic theory.

Through a careful and creative approach to this problem, he built the core of his enduring contribution to human development and to psychoanalysis. The model of the sequence of interactional issues (Sander, 1962) described, organized, and gave theoretical coherence to the massive volume of disparate observations and interviews we had collected. This was a major breakthrough in the understanding of the way in which the baby’s maturational unfolding and the mother-infant dyadic interaction combine to shape maternal and family development as well as infant development. Simply stated, the rapid postnatal growth of the infant’s central nervous system presents both of them with a sequence of developmental challenges which the pair must negotiate together, to establish or fail to establish the mutual regulation of rhythms and affects, and the recognition of each other.

Central to this dyadic process is the subjectivity of being known by the other. We heard the mothers verbalize in a state of almost ecstatic awareness. “My baby knows me!” The babies lack that linguistic fluency, but through their affect, their self-integration, and the specificity of their recognition of the caregiver, demonstrate the inner state of being known. Each partner is, in the empathic sense, known by the other, and, in the subjective sense, feels known by the other. This is not only a weblike psychological structure within which the self is constructed, but, as is suggested by more recent research, the matrix and necessary stimulus for key brain development (Schore, 1994).

In psychoanalytic therapy we struggle with issues of knowing and being known. The patient wants to be known, albeit through a veil of ambivalence about revealing and hiding. Nevertheless, if one does not feel known in some deep sense by one’s therapist/analyst, then counter-therapeutic feelings dominate.

FEELING KNOWN

An interesting issue being revisited in contemporary psychoanalytic work has to do with how the analyst creates an atmosphere in which the patient feels known, perhaps in a sense similar to what Lou was talking about in the babies. Beyond the obvious and ever-present matter of empathy as a key to feeling known, safe, and appreciated, are the additional matters of mutuality and reciprocity. Lou’s first two issues in the sequence of interactional issues. Can the feeling of being known be a one-way street? Can you feel known if you do not know the knower? Lou and others have shown that even very young babies “know,” in the sense of recognizing their mothers, and over time the subtlety and complexity of that knowing grows. Here the feeling of being known by the other and knowing the other go hand in hand. Certain religious doctrines and some psychoanalytic traditions try to separate these two naturally co-occurring aspects. God can know us, but we cannot know him. The analyst can know us, but he is neutral, the blank screen upon which we project our transference feelings, and therefore we cannot know him.

For many valid reasons, among which are the theoretical and practical impossibilities of remaining neutral, as well as the distorting consequences of such a one-way relationship, models of intersubjectivity are replacing transference models. Often the technical question for the analyst is framed in terms of self-disclosure. But the question of self-disclosure is the tip of an iceberg, the full substance of which raises all of the questions regarding the analyst’s relationship with the patient. It is much more complex than the narrow question of which facts about oneself an analyst reveals to a patient. Self-disclosure takes place via an array of communication channels, with affective communication being the most basic. We reveal our inner self to another as much with our affective states as with any set of facts about ourselves. While the
patients may present their wish for disclosure as a request for some factual statement or opinion by the analyst, the subtext has more to do with the patient wanting to know who the analyst/therapist is as a person at the deeper levels, in order to feel close, to feel safe, to repair the damaged self, to grow, etc. It is an attempt to pierce the professional mask and establish a reciprocal relationship. To be sure, unconscious fantasies of possessing, devouring, seducing, merging, etc., also exist. Pathology is undeniable, but it is shortsighted to neglect the normal desires for reciprocity, or to believe that therapeutic efficacy requires the frustration of those desires.

If we allow ourselves to look at the unnatural asymmetry of the analytic situation, we will be able to understand, first of all, that we, not the patients, are responsible for this unbalanced structure, and second, that there is a totally expectable and fundamental desire in people to reduce the imbalance created by that asymmetry. We know from decades of study of infant-caregiver relationships that there is a powerful innate tendency in both partners of the transaction to establish a mutual, reciprocal relationship (Sander, 1962). It takes only a minute of self-reflection to realize that without the universal exercise of that basic relational tendency, we would not be here as a species. In setting up the structure of analytic treatment, we are deliberately altering the normal social expectation for mutuality. We may have good theoretical, practical, and historical reasons for creating this somewhat dramatic break with the natural state of human interaction. However, no matter how valid the justification, any discussion of the patient's desire for us to disclose, and our response to that desire, must be cast within the context of human reciprocal interaction. I am not suggesting that the therapeutic relationship should be a re-creation of the mother-child relationship, or of any other real-life relationship. All I am saying is that, given the way in which we set up the analyst-patient relationship, we are asking the patient and ourselves to swim upstream against the basic current of the human condition.

In analytic therapy we have created a set of paradoxical challenges to the patients and to ourselves. The relationship is highly personal yet not fully reciprocal. It is humanistic and egalitarian inside a well-defined power structure. It evokes expectations of gratification while prohibiting that gratification. It is real and unreal. It is one-sidedly intimate. It is unbounded within tight boundaries. It is safe and dangerous. It works well only when both parties go right to the edge within apparently protected confines. It sets out to teach us a radically new and different view of ourselves and our relationships without engaging in any instruction. It is no wonder that we cannot fashion it easily from the stuff of real relationships.

Is there a workable resolution to these paradoxical features of analysis, one which responds satisfactorily to the patient's natural desires, yet maintains the uniqueness of the analytic framework? By not responding adequately to the patient's moves toward reciprocity, we create a cold, forbidding, and rejecting atmosphere, which is the antithesis of Winnicott's holding environment, but which nevertheless became part of analytic culture. The analyst's attempt to be neutral and non-gratifying was intended to facilitate explorations of the interior boundaries between the conscious and unconscious mind. The analyst also was trained to believe that the patient's attempt to break through the blank screen was a resistance, manifested as a wish to seduce the analyst into a gratifying relationship, thereby avoiding the work of analysis. With great discipline, the analyst maintained a blank screen, convinced that this position was simply one of neutrality. Therefore, any feelings of rejection or disempowerment, or manifestations of defensiveness or regression by the patient were the property of the patient, which must be reflected back to the patient for further analysis.

On the other hand, if we respond by granting the patient's expressed wishes for reciprocity and intimacy in the same language in which the wish is presented, that is, by revealing ourselves to the patient in the same way as they reveal themselves to us, we know all too well the
explosive and distinctly non-therapeutic consequences. Is the answer to this dilemma to reveal ourselves just a little bit, and then back off when we get frightened that we have revealed too much? That is indeed a poor solution, too much like the seductive dance of the seven veils.

AFFECTIVE PRESENCE

To resolve this dilemma, we need to alter slightly the terms of the discussion. Instead of the term self-disclosure, we should be thinking about affective presence and about mutuality and reciprocity. Self-disclosure carries such pejorative and erotic connotations that it is not open to fruitful discussion. It seems to imply the violation of some set of rules, and that our maneuvering is designed to offer something of value to the patient while hoping that the rule violations are not too blatant. This is a terrible and untenable place for an analyst to be.

Another distinction that is important to emphasize is that between neutrality and blank screen. More will be said of this later, but for now it is sufficient to state that while there is much to support neutrality as an analytic technique, the same cannot be said of the blank screen. It is now so discredited that one might complain that I am beating a dead horse in even raising the issue. But my experience in teaching and in supervising therapists leads me to believe that its ghost is still very much abroad in the countryside.

The developmental foundation for analytic neutrality is in some sense as primordial as is the foundation for affective presence. Sander (1983) has called our attention to the vital function played by open space in promoting increasing self-regulation, and ultimately, self-recognition. "The conditions for the differentiation of self and other can be seen to reside in the 'open space' condition of equilibrium in the system, and in the relative disengagement... of the self-regulatory core in its integrative function... (disengaged) from preemption by either endogenous or exogenous determinants."

Back to psychoanalysis. As soon as we shift the framework of disclosure from content items about the analyst's life to affects, and from self-disclosure to affective presence, mutuality, and reciprocity, the whole question eases, and we are no longer trying to balance ourselves on the point of a very sharp pin. This is not to say that there are not important questions about affective openness, but it is a much easier realm of discourse, allowing us to explore, without prejudice, how interactions take place, how messages and meta-messages pass back and forth, and how the intricate mutuality between the participants promotes therapeutic change.

This new realm of discourse centers around the dialectic between creating enough psychological space so that, on the one hand, the patient can enter into self-examination, self-reverie, absorption in the inner being, etc., without feeling the intrusion, or at times, even the presence of the other, while at the same time being sufficiently present to create a dyad. The therapist guides the patient in creating a therapeutic alliance, in developing trust and safety, and in sensing the underlying mutuality and reciprocity, even if it is not always in the foreground.

Not everyone agrees that affects are easier to deal with than facts or thoughts. For example, Spezzano states, "Affects are the most private type of information. Analysts need to be more cautious about disclosing their affective states than they are their thoughts. Affects are however knowable to listeners and observers even when speakers or actors do not verbally identify them. (Is it possible then that patients can figure out how we feel?)" (1993, p. 53).

What exactly does this statement mean? First of all, it highlights one of the chief ways in which affects serve as communications, namely, that they are complex yet often unconscious interpersonal signal systems, and that we deceive ourselves if we think that we can conceal them, particularly over the course of a long-term relationship. What then is Spezzano so worried about? That the patient will come to know us as we really are? That our presence as a living,
breathing human being will in some way impair the analytic process? That if we do try to hide, we will be unmasked? He says that because affect is the most private type of information, we must be cautious about disclosing it. But then he goes on to suggest that it is also the most public type of information because we cannot truly hide it.

Spezzano’s confusion is not a personal matter. It is rampant in our field. In part it is a holdover from the blank-screen era, even though most analysts today would probably say that the blank screen was a theoretical and technical error which should have been abandoned long ago. In part, we have not distinguished between the concepts of presence and self-disclosure. But most fundamentally, there is still no compelling model of affects that is integrated into clinical psychoanalysis.

**PRINCIPLES OF AFFECTIVE PRESENCE**

Briefly, and without any attempt to be comprehensive, the points that need to be made about affect, in terms of the analyst’s presence, in terms of the patient’s desire for reciprocity, and in terms of how the model can enhance therapeutic change, are as follows:

1. The therapist’s complex emotional being must be present in a very special and perhaps paradoxical way. That is, it must be there and not there at the same time. If we can accept the proposition that the world is full of paradoxes, and that our affect systems are particularly paradoxical in nature, propelling us in opposite directions at the same time, the idea of being there and not being there will not seem so strange.

2. Consciousness and unconsciously, our affect is communicated to the patient, who in turn perceives and constructs it in accordance with his/her own idiosyncratic processes. This is yet another paradox, as highlighted by Spezzano’s quandary. If we try to hide our affect, the most powerful message we may be communicating is exactly that—specifically, that we are trying to hide our affect. This is not the sort of meta-message we are trying to convey, if we believe that the essence of the treatment is that patients work hard to be open with their affects. Thus, we are there as therapists not only to create a safe space in which patients can feel increasingly free to explore their interior, but whether we like it or not, we are also there as models of how this open reflection is supposed to take place, and where it leads.

3. A blank screen is not a neutral presence: it is a powerful communication of non-presence. Furthermore, as this technique devolved from master to student, down through the generations, it became a caricature of human interaction and of analysis. Rather than creating an atmosphere of the therapist’s mature restraint and support in the face of the patient’s affective storms, we saw instead the much cartooned analyst saying “um-hm” in the face of every intense struggle and trauma of the human condition. The training process for bringing aspiring and neophyte therapists into the fold had many of the features of an exercise designed to create a false self. The anxious young therapist was all too happy to take on the cloak of an enigmatic presence as self-protection, and as a mantle of distant authority. Being an oracle fulfills so many childhood wishes. It is so safe and so powerful. The therapist finds it especially useful, when feeling weak and unsafe. If this tendency is promulgated and reinforced by the culture into which one is being indoctrinated, we can all too easily spend our entire professional lives talking to our patients with a different voice than we use for any other human interaction. This costume may be so appealing to us that our own developmental process may proceed in the wrong direction. That is, instead of us
becoming more relaxed and more genuine with our patients as our hair grays, we
generalize the costumed self, and become more remote and more pontifical in all of
our relationships.

4. The therapist must come to know and trust his emotional being so that its states are
familiar and its displays are genuine but not uncontrolled. This is one of the major
purposes of the therapist’s personal or training analysis. The thoughtful awareness
and tolerance of affective states, pleasant or unpleasant, fleeting or sustained, is one
of the objectives of psychoanalysis. What do we communicate about this fundamental
aim if our own affects are not in the scene? The analytic attitude should convey a
healthy engagement with our affects, not a masking or cloaking of them. How can we
carry out a treatment, a major aim of which is to access, comprehend, enrich, anneal,
and organize the patient’s affective being, if our own is hidden behind a confessional
screen?

5. No matter what we do as therapists, we are going to be the objects of transference
and the targets of projections. A lot will be coming from the patients, but it will not
be divorced from the cues we are consciously and unconsciously sending. In light of
this, what kinds of cues do we want to send? The most fundamental message we need
to send is that we are there with the patient as a total human being, exercising the full
scope of our empathy and our emotional availability. This is not the same as imparting
a specific message or point of view, but we have not, in the service of not imposing
our own point of view, removed ourselves from the scene. The blank-screen mythology
is that by removing our affective being, we will not be biasing or squelching
those transferences or projections. We now know that they are unquenchable, but
more to the point is the observation that we are deluding ourselves if we think we are
not biasing them. By removing our affective being, we will be biasing those transferences
and projections in a particular direction. Clearly it won’t be the same for all
patients, but in general I think it is fair to say that around Oedipal conflicts, we are
setting up ourselves and the patients for superego associations, defenses, and conflicts,
and then whatever personal reactions the patient has to that arena. With respect to pre-
Oedipal organization, we are setting the stage for scenarios of deprivation and with-
holding. We as therapists do not create the patient’s associations, but we may be
defining the arena.

6. A similar condition applies to other affective states, such as ambivalent feelings. Not
only can we validate the patient’s ambivalent feelings by sharing our understanding
that ambivalence is one of the inescapable realities of life, but we can, within a meta-
aphoric frame that is consistent with the patient’s way of thinking, share the ways in
which we have come to appreciate and deal with some aspect of our own ambivalence.
That is, we can share not the content of any particular conflict that we have worked
on for ourselves, but rather the process through which ambivalence is understood and
encompassed.

7. An important example of the necessity for being genuine regarding our affects is
presented by Malsberger and Buie (1974) in their clinical work with suicidal patients.
Such patients may act in ways that generate anger in the therapist. It is the job of the
therapists to comprehend how and why that anger has been stirred up in them, to
recognize their anger at the patient, and to not cover it up from themselves, or to feel
that it must be hidden from the patient. Covering this anger and not sharing it may
lead to the more dire consequence of abandoning the patient. In essence they say that
the patient can tolerate our anger, if presented in a restrained and caring way, but
cannot tolerate the abandonment, the likelihood of which is increased if we attempt
to deny or stifle our anger.

8. Affects are our motives, our inner regulators, and our primordial communication sys-
tems. They span and encompass one- and two-person psychologies. They modify our
communications and are modified by the messages we receive. They are fluid and
sustained. They come in all levels of intensity and all colors of the spectrum. They
come in a bewildering array of blends, displacements, reversals, and sequences. At
times we feel more possessed by them than owning them. Not only do we have poor
understanding of them as a system, we are all more or less guilty of Descartes' error
(Damasio, 1994), which is that we believe that they degrade and interfere with our
higher mental functioning. As Damasio so well demonstrates, the opposite is true.
Without our affects as beacons, as the evaluation system of all of our experiences, we
are lost and aimless.

9. A key aspect of knowing our own feelings is to appreciate the power and ubiquity of
ambivalence. We see it in ourselves, in our patients, and in the world around us. From
Freud onward, psychoanalysis has highlighted the love-hate polarity, which endures
as a clinical and affective touchstone, whether or not our particular psychoanalytic
bent accepts or rejects the dual instinct model. The analytic stance of neutrality was
adopted in part to deal with the universality of ambivalent affects in patient and in
analyst. Rather than following the disastrous path of siding with one half of the ambi-
valence or the other, analysts felt they were being maximally useful to the patient
by remaining neutral with respect to the choices and polarities. As a strategy it is
certainly preferable to taking sides, but it completely misses the point of being able
to stay in empathic contact with the patient. Being "neutral" in the face of an intense
conflict has some therapeutic value, but it can all too easily communicate remoteness.
Is that in fact the moment when the patient is likely to try to elicit some juicy tidbit
from us, leading us down the path of self-disclosure? Do we feel tempted to offer the
morsel precisely because we feel we have affectively abandoned the patient by re-
main ing neutral in the jaws of the conflict? Is the seeking and the granting of the
disclosure a mutual attempt to reestablish contact and repair the breach that was created
by our neutral remoteness in the face of the patient's legitimate need and desire for
our affective presence? There is, of course, a much better way to handle the scene,
and by implication, the entire treatment. First of all, we must be able to encompass
and empathize with both poles of the ambivalence. There is a lot more to say about
this from a technical point of view, particularly about what avenues are open to us
when only one side of the ambivalence is consciously available to the patient. How-
ever, that is for another article. For now the important point is that in addition to being
able to empathize with both sides, we must also be affectively present, giving thought-
ful consideration to our feelings, rather than trying to hide them, and being able to
reflect with the patient those feelings about the intensity of the shared pain. Again the
paradox. We must be sufficiently secure with our own pain, and sufficiently trusting
of the patient's capacity to tolerate the pain, in order to leave him alone with it for
some period. At the same time we find a way to deliver the meta-message that he or
she is not alone with it; that together we have built up a container of reciprocity such
that aloneness is never total.

10. Classical analysts hold that the process of internal awareness and regulation, one of
the key functions we are trying to promote in analysis, is made possible via the restraint
and neutrality of the analyst. As stated above, Sander, in discussing state regulation
in the infant, notes the contribution of the open spaces provided by the mother within which the infant tolerates the caregiver’s absence for increasing periods, an essential part of the development of self-regulation. Via attuned recognition of the patient’s state regulation, analyses can regulate their own affective presence in the same fashion, so that it is there when needed and restrained when it would be perceived by the patient as intrusive. There is no reason why analyses should adopt a fixed stance regarding affective presence as a technical doctrine. Affective presence or remoteness itself should be a regulated function in relationship to the patient’s affective states. Do we have to tune perfectly in order for a good analysis to take place? There is evidence from infant research (Beebe, Jaffe, Lachmann, Feldstein, Crown, & Jasnow, 1999) and from clinical experience that partial attunement is not only the rule in well-regulated pairs, but is preferable to something approaching perfect attunement. Partial disattunement in fact creates a kind of second-order space in which room is left for the infant or the patient to assert an initiative into the interaction. To always be met by the perfect other can be rather disarming and antithetical to the development of initiatory and flexible, resilient self-regulation. Obviously, if the attunement is too far off, and the patient’s states are consistently misread in terms of the desire for mutuality, a deadening can take place at either end of the attunement spectrum.

DUAL SPACE

The challenge for us is to create a dual space inside the therapy. In one space we are neutral, observant, allowing a lot of room for the patient to look inward and yet the freedom to be with himself, but because of the reciprocity inherent in the second space, not by himself. This may sound mystical but it is not very different from what takes place in our ordinary experience. While this duality may be common, it may not be very familiar to us. It does not seem familiar because it is a complex process that takes place outside of our focal awareness.

At the heart of this process is the fact that communication between people takes place at many levels simultaneously. In speech alone a multitude of factors carry information. These factors include the content, the surface message we are trying to send; through choice of words, the entire realm of metaphor (processed by the right-brain speech analyzer) and double entendre in which we are able to communicate multiple messages in a single phrase: statements that are straight; and statements that are paradoxical, containing subtle and not so subtle internal contradictions. Other factors are the rhythm, prosody, choice of vocabulary, sentence structure, the complex signals, rhythmic interplay, and synchrony that signal whether we are talking with someone or at them. Further levels of information are carried by facial expression and color of complexion, eye movement, bodily posture and movement, microkinetic synchronization, breath patterns, and other vocal signals of affect. The permutations of this system are literally beyond calculation. Yet we are phylogenetically and ontogenetically equipped to extract volumes of information from this incredible array, some in the millisecond range, some integrated over much longer periods. In this system, we remain largely unconscious of what we are sending and what we are receiving, yet powerful meaning is conveyed at every moment.

Thus, it is not a special or novel task for us to create two or more spaces. We are always doing it, whether we know it or not. Sometimes it is viewed in negative terms, such as the problem of sending mixed messages, one of the most common complaints in families. If we are tuned to ourselves, and recognize that our goals is to send the paradoxical set of messages that we are neutral and affectively present at the same time, it becomes an entirely doable task.
Now our focus shifts to an entirely new frame, in which nondisclosure is an impossibility. We can return to Spezzano's quandary, and realize that the attempt to micromanage communications through a certain "analyst's voice" only makes things worse. We can see that the critical question is not how to control the communications. Rather, we ask what is the essence and the deep structure of what we inevitably communicate?

By essence and deep structure, I mean many different things. Some of it is our basic attitude and belief system about the work we are doing. For example, if a patient shows a rapid improvement in symptoms early in the treatment, do we automatically think to ourselves that it is a flight into health, a transference cure, something that is destined to disappear as quickly as it came? If so, then I can assure you that we communicate this overtly or covertly, and lo and behold, are soon able to demonstrate the truth of our supposition. As patients search for the causes of their plight, which in my experience is a never-ending preoccupation, we have to ask ourselves what our own assumptions about psychological causality are. How do we deal with the likelihood that the patient's deep explanatory system may be contrary to ours, or what do we think about the relevance of the whole question of causality? It is worse than naive if we think we do not have core beliefs, or that in some way or other we do not convey or transmit these to our patients.

What are our deep feelings about our patient, and about his or her family? In couples work, how do we deal with the inevitable disparity of feelings toward the two spouses? How do we take the views that the patient has constructed of his or her world, and simultaneously validate and reframe them? Do we consider the patient's view to be distorted and pathological, while ours is undistorted and healthy? If we hold to a concept of psychological defenses, are we then standing inside or outside of the patient's own mental frame?

At an even more fundamental level, what is our own characterological, what is the state of our narcissism, are we optimists or pessimists, how do we manage our shame, how do we react to rage, sadness, conflict, etc.? Aspects of who we are, in time, will be communicated in much of their richness and complexity. Let us accept that, and see that our task is not to hide, but to create this double space where we are both neutral and affectively present. By the end of a successful treatment, the relationship between patient and therapist has many of the qualities of an I-Thou relationship (Buber, 1923, 1970), limited of course by our professional obligation to remain in different life-spaces.

The argument has come full circle and we are confronted with a counterintuitive solution to our paradox. What is now clear is that the likelihood of the occurrence of clandestine self-disclosure increases when we try to stifle our affects, and decreases if we are affectively present, and relatively free. If we are there with the patient in a relaxed, free, playful, creative, shared mode, creating the double space, then they will not be searching for those displaced signs of our availability and caring, and we will not be feeling we have to provide them, perhaps out of guilt, or perhaps to feed our own narcissism, which may feel damaged and deprived by our rigid anti-exhibitionistic discipline.

How do therapists share and communicate their affect without specific self-disclosures? As we come to know our patients, we become familiar with the metaphors each one uses to talk about themselves and their lives. The imagery is highly personal, and reflects their own cognitive-affective style, core conflicts, affect language, views of primary objects, specific profession, personal interests, etc. By entering into their metaphor, using their language and imagery, it is possible to be there with our own affective presence, but in their frame of reference. People want to know, "Do you know what I'm talking about?" They are asking whether we can understand and respond to them in the same language and metaphor that they have used to address us.
CONCLUSION

The crib and the couch are not the same, but neither are they completely different. The mathematician Douglas Hofstadter (1980) gives a wonderful definition of intelligence. He says it is the ability to see similarities in different situations and differences in similar situations. So let us try to be intelligent.

Affective reciprocity is the sine qua non of healthy intimate relationships, and an essential ingredient in caregiver/infant interactions insuring the richness of early development. For long periods in the history of psychoanalytic theory and technique, the withholding of the analyst’s affective presence was promoted as essential to the formation of the transference neurosis. This transference neurosis then became the substance from which the analysis proceeded — no transference neurosis, no analysis.

The underlying assumption is that a deep and enduring change in a person’s psyche requires a destabilization and dissolution of existing pathological structures, and that one way of inducing that destabilization is deliberately to violate the normal social expectations around reciprocity. The analyst then observes and interprets the fallout from this process. It is interesting to note that there is a similar developmental assumption regarding the dissolution of early neural and psychic organization as a necessary step in the generation of new, more complex structures. However, only the most Spartan of childrearing approaches recommends the withholding of reciprocity as the preferred pathway to that change. Why then is the withholding seen as necessary in analysis while not even recommended in parenting?

We know that there will always be enough misconceptions in any therapy to generate the breaches that will destabilize the existing structures. There is no need to go out of the way consciously to create even greater destabilization. In this sense the affective posture of the analyst need not be that different from that of the good parent. The necessary differences (between analyst and parent) exist in the realms of narcissistic investment, responsibility, confidentiality, countertransference, conscious and unconscious agendas, the contractual nature of the relationship, and the time-limited structure.

But with regard to affective presence juxtaposed against open space, the similarities are the dominant features.

I felt known by Lou and I hope he felt known by me.

REFERENCES


