Psychoanalytic Dialogues

Affect: The Heart of the Matter

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Current understanding of the process of therapy and development focuses on the interactions between the partners. The interaction is a negotiation of differences and of change. The equilibrium of the relationship is inevitably subject to frequent destabilizations, by virtue of normal developmental processes, life events such as losses, and the divergence of aims as each process unfolds.

The destabilizations are pivotal to the creation of new states. If a newly emerging state is to be advantageous for the development of the infant or the health of the patient, the associated toxic affects have to be tolerated and dealt with openly. If the analyst defensively hides, opportunities for change will be lost and the old patterns will persist. The therapist and patient, like the parent and child, are engaged together in this mutually altering process.

In relational psychoanalysis, the essence of the analyst’s part in the treatment has been transformed from interpretation to negotiation. Negotiation necessarily demands that the therapist be a living, breathing, interacting human being. And further, since affect is the heart of what must be negotiated, the therapist has to be an affective presence, albeit a contained one. Paradoxically, the therapist has to be there and not be there at the same time (Russell, 1998).

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This paper is dedicated to the memory of Paul Russell, M.D. It was supported in part by the Jack Spivack Child Development Fund.
I think I need to begin by assuming, by asserting, the absolute centrality of affect. The work of psychotherapy amounts to the problem of affect. The moment there are more than two neurons between receptor and effector, the moment there is a delay between stimulus and response, the moment when choice is possible, one is presented with the problem of affect. . . . All agencies of the mind report to affect [Russell, 1994, p. 1].

The neurologist Antonio Damasio (1994), also asserting the centrality of affect, turns Western rationalist tradition on its head, so to speak. Affects are not the disrupters of our thinking, as is universally assumed, he writes. Rather, they are a vital part of the guidance system that gives directionality, purpose, and meaning to our thinking. Patients with a variety of brain lesions that interfered with their affects, but not with their intellectual functions, had the greatest of difficulty in all life’s complex domains. They were socially inept and inappropriate, unproductive in work, and lost in aimless activities. Damasio makes a strong case for a higher order integration of subsystems at the neural level and at the functional level to make it possible to carry out complex adaptive tasks. It is not that the affective systems carry out that feat on their own. Rather, affect is an essential subsystem whose activity contributes a unique and irreplaceable link in the complex web that is human psychology.

The fantasy of a Mr. Spock from Star Trek who can get everybody out of a tight scrape because he does not get caught up in his emotions is just that, a fantasy. In the known clinical reality of Damasio, a man without feelings is not more dependable. He is thoroughly unreliable in decision making, in planning, in organization, in learning from experience, in interacting with others, and in meeting novel or complex circumstances. Affects are the beacons, the compasses, and the storage bins for our complex social experiences and intentions. There is no adequate navigation through life without them, even though we have been taught to see them as the unruly parts of our lives, parts that must be tamed and contained.

Silvan Tomkins (1962) also views affects as the centerpiece of our complex psychic apparatus. Tomkins was impressed by the problem of the drive theory of motivation in psychoanalysis and also by the lack
of an adequate psychoanalytic model of affect. Tomkins (1962, 1963), addressing this dual problem, gave psychoanalysis a comprehensive model of affect and a new answer to the nature of motives. For our purposes a few salient points about this model are useful.

First of all, Tomkins's model addresses a key point that is dealt with inadequately both in classic analytic theory and in the modern relational approach, namely, how do we understand the push and pull of desire? There is no question that psychoanalytic thinking continues to suffer from a lack of a coherent, comprehensive perspective on affect. Even relatively sophisticated modern discussions of such issues as love and hate seen either from a relational or an object relations point of view tend to be very rich in phenomenology but do not even venture into the underlying theoretical framework within which to locate these phenomena.

Thus, while we may agree that affect is at the heart of the matter, when one ventures within psychoanalysis to examine this heart, there is a terrible void, at least with respect to conceptual maps. Tomkins tried to fill that void with a comprehensive model of affect that was compatible with psychoanalysis although it did question some key Freudian assumptions. To my mind there are two critical disagreements between Tomkins and Freud that kept Tomkins's model from becoming widely accepted within psychoanalysis. The first is that Tomkins identified affects, not drives, as the basis for understanding motivation; and the second is that Tomkins followed the Darwinian model of inborn differentiated affects, rather than the cruder pleasure principle, or the dualistic libido/aggression model of psychoanalysis (Freud, 1920). It has taken more than 30 years to overcome the first of these psychoanalytic objections. Now even died-in-the-wool drive theorists such as Kernberg (1993) agree that motives have to be conceptualized as clusters of affects.

The second objection may take longer to dispel because the relationship between psychoanalysis and evolutionary biology is in a state of ferment fueled by the longstanding contest between the scientific and humanistic strains within psychoanalysis. Furthermore, Tomkins's work itself is no longer an adequate model, albeit a good starting point. Research on affect has burgeoned so nicely in the 40 years since his magnum opus that we would not be doing a service to our work to simply try to import Tomkins at this point in time. Some aspects of his model, however, may still be of value to us because his fundamental assumptions are so sound.
Tomkins views affect as occupying a broad band of our psychic system. One of the boundaries of this band touches on direct automatic physiological reactivity to inborn stimulus–response connections, while the other boundary interacts with the symbolic and metaphoric representations of our language. Modern neurophysiological research on affect, such as the work of LeDoux (1996), confirms that there are two distinct systems and pathways for affect, one a direct subcortical set of circuits, and the other mediated through complex cortical connections. Tomkins also sees affect as the rapidly recruited powerful amplifier of our drive states, such that it is the affect configurations, rather than the physiological drives themselves, that are the true foundations of our motivational systems.

A brief list of some of the most salient qualities of our affect systems will give you a flavor of their richness and complexity:

- They are the vital part of our internal regulatory and motivational functions, and at the same time the primordial and lifelong communication channels of our interpersonal relations.
- They are the most volatile and changeable, yet the most repetitive and enduring, aspects of ourselves.
- They tell others about our states and inform us of the states of others.
- In social encounters, other people, including our patients, may be more aware of our affects than we are. We show our facial expressions to others, but we ourselves may be quite oblivious to those expressions.
- What we feel and express, even with great conviction and intensity, may, in fact, be a cover affect, while that which is being covered remains outside our consciousness—for example, anger may be a cover for sadness or shame.
- Feelings are basic elements of a primitive nervous system and yet are tied to the most subtle and sophisticated nuances of our symbolic, poetic, artistic, and creative aspects.
- For the most part, particularly when affects are intense, they tend to exist as polar pairs: love and hate, fear and fascination, activity and passivity, and so forth. In this sense, all feelings are ambivalent, but they are often split, one of the poles remaining repressed and unconscious.
- Related to polar ambivalence is the possibility of very rapid nonlinear shifts to the opposite feeling.
- We all struggle with the core question of how deeply ingrained affective patterns can be changed through therapy. Some of them are fundamentally resistant to change while the rest only seem that way.
Relational psychoanalysis puts us in the affective arena with the patient—with the knowledge that being there, with our own emotional equilibrium exposed to disruption, is the only pathway by which deep change in the patient’s own affective system can take place. Thus, it is not only the patient’s affect that is at the heart of the matter, it is the analyst’s affect and affective competence that is at the core of the care. Part of that affective competence is at the gut level: how we, as analysts, have come to terms with our intense interior processes. Part of that competence derives from an empathic stance, so that we can hear and feel the metaphors through which the patient is struggling to communicate an interior state; can hear the patient’s metaphors without the intrusions of our own metaphors and without the pressure to translate and transform the word pictures into our language.

Lou Sander (1962) introduced negotiation as part of a theoretical framework for the analysis and understanding of the data we were collecting in the Boston University Longitudinal Study of Early Development. Lou had to go outside the framework of psychoanalysis and rely on the early general systems biologists, such as Paul Weiss (1969) and Ludwig von Bertalanffy (1949), to find ways of thinking that made sense of the mother–child observations from the study. Sander saw that the exchange between mothers and infants was an active, mutually shaping process. The baby was highly active in the exchange from the outset and was, in a most profound sense, the one who set the agenda for the interactions by virtue of the unfolding sequence of developmental issues that marked the normal neuromaturational process.

For example, from the moment of birth, a baby’s short-span sleep cycle confronts the mother with a central challenge that the two of them must negotiate together so as to bring the baby into a reasonable approximation of the normal adult diurnal cycle. For the mother, this is a matter of some urgency. If you ask a new mother how she feels about this process, she will let you know that she feels disrupted, sometimes to the point of disorientation and desperation. If the babies could talk, they too might say that life feels pretty disrupted and often distressed. Even without talking, their affective displays of intense distress, which sometimes are very difficult to assuage, clearly communicate their stake in reaching some accord. These initial mutual
adaptations are not easy, particularly with both partners in states of affective volatility and internal dis regulation. But it is precisely the separate individual disregulations that leave both of them open to the negotiation of new patterning.

One of the key features of this mutual adaptation is the high degree of specificity that identifies each mother–infant pair. While the goal of reaching coordinated sleep–wake cycles is universal to all families, the exact affective signaling systems, the details of the patterning of soothing and arousal, and the maintenance or termination of microstates are unique to each family. In one study, we used a live-in nurse to provide round-the-clock caretaking for babies who were on their way to foster or adoptive placement. One of the investigators substituted for the nurse on the seventh postnatal day in order to give the nurse a break. During that eight-hour daylight shift, the baby could not go to sleep at all, despite having established a fairly regular sleep–wake pattern by then. All efforts to soothe and comfort the baby were futile, and he stayed in an on-again, off-again fretful state for most of the day. That situation, in and of itself, was not remarkable, because we had already established that, with well-tuned mother–infant pairs, the baby acquired specific recognition for the caretaker’s actions within the first week of life, as demonstrated by the regularity of the four-hour activity cycle under that person’s care. What was so startling and illuminating about this particular event was that, when the nurse returned at 5:00 PM and saw the fretful baby in the investigator’s arms, she spoke from the entrance to the room, some 10 feet away from the baby, and softly said, “What’s the matter, baby?” Whereupon the baby instantly quieted and went into a steady and prolonged sleep state.

The possibility of the emergence of new states and new organizations arising during times of disregulation and apparent disorganization or chaos has become one of the hallmark principles of contemporary theories of self-organizing systems (Prigogine, 1978). If disturbances to existing states are quickly damped down and the state is restabilized, the old state, as the term implies, is reinstated. For a new state to emerge, the fluctuations must increase in amplitude until some threshold is reached and there is no return to the original state. Instead, there is a bifurcation, with the system moving into one of two new possible states. One possibility is simply a random 50/50 chance of the original state A going to one of the new states B or C. However, because of the instability at that moment and because the local, semiopen system is more open to the exchange of information and
energy with the surrounding system at that moment, the characteristics of the surrounding system can have a specific bias or influence on the choice of the new state-to-be. Through many iterations of this bifurcation process, even a slight but steady bias from the outside will drive the local system into a unique pathway and state outcome. This is one of the ways in which the abstract theory of self-organizing systems can characterize the very real and concrete finding of specificity in the development of interacting mother–infant pairs.

To conceptualize the parent–infant dyad in the framework of self-organizing systems, we need to introduce the interaction of two self-organizing systems, each representing one of the partners, which are then joined together in an enveloping self-organizing system, representing the dyad itself. Since the theory of self-organizing systems is not constrained to any scale size—it may range from the most minute to the entire universe—we can think in terms of nested systems in which larger systems encompass smaller ones.

Now, able to envision two such systems interacting within the envelope of a third, we have a theoretical model of negotiation that can apply equally well to early child development and to the therapeutic process. Key to this conceptualization is that both local systems are engaged in a process of mutual influence and the biasing of change in the other. There is nothing inherent in this model that says that the biasing has to be equal, or that one or the other of the local systems is in a particularly privileged position. The implication is that the more stable of the two systems, the one less susceptible to large fluctuations, is less likely to evolve into new states and therefore is less under the influence of the other. Any degree of symmetry or asymmetry is possible within this framework. Even though what is going on between the two systems could be described as a negotiation, parity is not implied.

At the extreme of a hypothetical continuum, one of the systems can be fixed and not open to change or influence by the other—a caricature of the traditional analyst or the rigid, unempathic mother. At the other extreme one might find nothing but chaos and instability, leading in the family situation to the phenomenon of parentification, in which the child becomes the caretaker, or in the therapy situation to a major boundary violation. Neither extreme would be seen as a negotiation.

Let us note that mutual influence between two people is no more than a biasing of the outcome, and not an absolute determination of
it. Each system retains its own self-organizing properties, and no matter how intimate or prolonged the interaction between the partners, each has the capacity to choose a direction that may be surprising to the self and to the other. Unexpected nonlinear shifts may happen at unforeseen moments.

Pivotal moments in our life experience consist of the negotiation of crises. Our capacity to reorganize around crises is what makes our lives possible, and what makes us human. In a cartoon in The New Yorker, Adam and Eve are shown, hand in hand, leaving the Garden of Eden. One is saying to the other, “This is a time of great transition.” In Chinese, the word “crisis” is represented as a combination of the characters for “threat” and “opportunity.” In therapy, the work often consists of a renegotiation of old patterns, facilitating the creation of new organizations and new states with respect to those preexisting issues. Over the course of development, powerful, entrenched, and often contradictory affects have been generated and are now firmly attached to sets of perceptions, relationships, desires, memories, and so on. Some of these configurations may be so firmly entrenched that we have come to call them neuroses, addictions, character formations, repetition compulsions, or self-pathology.

If one thinks of negotiation or renegotiation as a smooth, harmonious process, with two well-intentioned, thoughtful people sitting across from each other, trying to resolve differences, think again. Negotiating has all the volatility and intensity and resistance to change that we are familiar with in more traditional therapy, plus more—more because the negotiating therapist, as contrasted with the interpreting therapist, introduces his or her own affective being into the negotiating process. In the course of intensive therapy the therapist’s own being is challenged and open to alteration.

Russell (1998) has explored and illuminated this critical area for us and had made it a centerpiece of his work. At all times the therapist’s affective presence is there in the room, although our discipline and self-analytic capacities help us to foster the asymmetry of granting the vast bulk of the available space to the patient. At some point or points in the course of long-term intensive therapy or analysis, however, the destabilization of the patient’s affective being will intensify and will bring about a parallel destabilization of the analyst’s affective being. Russell called this moment the crunch and saw it as a necessary and pivotal transformational epoch in the treatment. Both parties are challenged to the utmost. Preexisting states are destabilized, and, as
in the bifurcation process noted in the discussion of self-organizing systems, some new state or organization must be created. It may or may not be a favorable change, but there will be a change. And that holds true for both parties and, most important, for the relationship between them.

The crunch is characterized by the loss of grounding in the therapist’s affective being. He is swimming in a soup of his own memories and feelings and finding no easy or ready anchor points. We have all been there and known the pain, anxiety, and maybe even the shame of feeling so uprooted from our established sense of ourselves. There is no way to reassure ourselves that this is a good place to be. But, if we can maintain even a shred of perspective that this is a moment when something important can happen for us and for the patient together—rather than trying to get away from such a hellish place—we may be able to use all this disruption to some advantage. On the other hand, if we do meet it defensively and try to escape in one way or another, we are likely to direct the change at the moment of bifurcation into a less favorable pathway.

We can use the experience of this uprooted state as a foundation for empathy with our patients and their sense of devastation and resistance in the face of such disorganization. In addition, the way in which we move forward from this chaotic state inevitably is communicated to the patient through unconscious and barely conscious channels. Affective communication may contain body and facial language, of which we are usually unaware, as well as symbolic and metaphoric language, of which we are usually at least partially aware.

The primordial and metaphoric messages we are sending tell whether we ourselves are seeking a place of refuge or a place of growth in the face of the disorganization. If the former, we will be biasing the patient’s new state selection in that same direction. This is the moment when the two participating self-organizing systems are maximally interacting, maximally engaged in a process of mutual influence, and maximally open to change, for better or for worse.

We can now return to Sander’s (1962) idea of negotiation between parent and infant in the sequence of early developmental issues. Let us take the example of two pivotal developmental tasks, reciprocity and initiation, and the transition from the first to the second. The onset of reciprocity as a key issue is signaled by the appearance of a social smile in the infant at about six weeks of age. Until that point
the central issue has been mutual state regulation as explained earlier. Mutual regulation continues as an issue—but now a new ingredient and a new level of negotiation of affects are introduced for the pair. The parent needs to respond to this social smile with her own affective display; if that is lacking, the baby's smile will wither (Provence, 1967). If the parent does respond, the pair now begins to engage in a dance of reciprocal excitation, which can be sustained for 10 to 15 minutes by the time the infant is three months old. To sustain this exchange, the parent must, unconsciously of course, regulate the level of excitation, by modulating the interplay between the novel and the familiar elements in it and closely watching the changing state of the baby. At one level, this new self-organization of affect around excitation and joy seems to be the simplest and most desirable activity for the parent, and for most it is. But, for some parents—too depressed to feel or express this joy, too tightly wrapped to coo and goo and roll on the floor, or too flooded by their own affects to be able to calm down when the baby starts to signal overexcitation—this activity is anything but easy.

But let us assume that the issue of reciprocity has been reasonably well negotiated by a healthy pair, resulting in a large measure of joy for both, enough to counterbalance the bouts of distress and disruption that are an inevitable part of life. By about six months of age, the infant's ongoing neuromaturation will introduce a major new element into the dance. No longer restricted to a largely reactive role under the parent's orchestration of the interaction, the baby starts to take the initiative in calling the tune. The baby will reach out to the world to secure something she desires, whether it is the spoon the father is holding while feeding her or the mother's presence itself. The baby becomes the creator of her own plans and an active partner in setting the stage for the interaction. Initiative and intentionality are no longer the sole property of the adult member of the pair.

It does not take much imagination to foresee how this new pattern demands a new level of negotiation. Since the two sets of self-originated plans may well be on a collision course, not because the parent and the baby intend them to collide, but because of the nature of independent realities, conflicts and struggles for control may ensue. In one of the families from our longitudinal study, the issues of mutual regulation and reciprocity had been well negotiated, but when the child started to initiate his own plans, the mother stated with an
ominous prescience, “They’re starting now.” She was referring to the initiatives coming from her son. There ensued an unbelievably intense struggle for control, which both of them lost. When the child could not overcome the mother’s control through his persistence and ingenuity in pursuing his plans, he fell into a passive resistance, and both of them lost the capability to negotiate a progressive course of development. As happens so often in family interactions, they defeated each other, with disastrous consequences—at least for the next 25 years.

In healthier situations, these issues of autonomy and individuation do not present the do-or-die choices just noted. The bond between the two can withstand the differences and, in the language of George Klein (1976), the *I* self and the *we* self can thrive simultaneously.

Now we can see two different but related meanings of negotiation that, when taken together, are fully consonant with the premises of the theories of self-organizing systems. In one instance, negotiation refers to the nature of the interaction between two parties who are engaged in a common project. In the other, it refers to the evolution of the project itself and the negotiation of the transition from one phase to another. In this sense it resembles the common usage, “We negotiated the rapids in our raft.” The way in which the two paddlers negotiate with each other will influence the way that the raft, as well as the paddlers, negotiates the rapids.

This double meaning is applicable both to therapy and to development. The therapist and the patient negotiate the relationship between them, and together they negotiate the changes that take place in the therapy, which then influences their respective lives. The phrasing is almost identical when applied to parent and child. The child’s affects, actions, and initiatives present challenges to the parent that, as any parent will tell you, can be most destabilizing. In an optimal interaction, the two can negotiate this turbulence in ways that promote the development of new and more complex adaptive and relational structures. For this to happen, both partners must change their preexisting organization.

Let us not dwell on the long and complicated arguments about the similarities and differences between the crib and the couch. Obviously, at the level of comprehending nonlinear dynamic processes, although not necessarily at the level of the specifics, there are important parallels. The therapeutic situation and the home environment are both self-organizing systems that are subject to stabilizing and destabilizing interactions.
Change

For change, and ultimately for growth, both stabilization and destabilization are essential. At home, in families with small children, we see the destabilization clearly. It is driven by the maturational engine that is moving the child’s development forward, and by the multitude of life events that affect families from all quarters. In therapy destabilization is a little less obvious, but there are numerous sources for it. One is the overt desire of the patient for change, no matter how many covert wishes there may be to not change. Another is the intimacy and steadiness of the situation itself. The therapist, in the process of holding a steady course close to the patient and not reacting to the patient’s moves to repeat past relationships, paradoxically destabilizes the patient’s preexisting patterns. The therapist does not have to make specific moves to destabilize the patient’s inner organization. The patient will do this himself when met by the therapist’s unexpected acceptance and validation of provocative affects. The patient seeks stability through the unconscious enactment of his repetition compulsion in the transference. If he can engage the therapist in the ritualistic encounters reminiscent of his family life and of other relationships, he will be able to maintain the uncomfortable stability that has been the pattern of his life. These relational patterns may have been fraught with conflict and turmoil, but they are stable nevertheless because of their persistence.

But the therapist does not enter into the patient’s expected paradigm for the repetition compulsion. Through that rejection of the ritualized repetition, he destabilizes that long-held pattern. He instead establishes the specificity of interactional patterns characteristic of healthy parent–child relationships and thus provides a safe and secure context within which the destabilization may be tolerated. Remember the baby hearing his nurse’s voice. In treatment, that specificity is built over time by steady empathic connection, by entering into the patient’s metaphoric world and language, and by knowing and being known by the patient.

We all believe that it is essential that our patients feel known by us. But this belief raises an interesting conundrum. Is it possible to feel known if we do not know the other? Can this kind of knowing be a one-way street? I believe that much of what has been interpreted as a
voyeuristic oedipal interest in the analyst’s body in fact represents a
primordial yearning for reciprocity, a wish to know the knower as that
baby knew that nurse and felt known by her. If we are to be known,
how are we to be known? For me, there is only one answer. We are to
be known by our affective presence. That does not mean that we cease
to be therapists and become buddies—or worse. Our affective presence
is itself a steady state that facilitates safety and intimacy, although, as
has already been noted, it is of particular importance at crunch time.

While the therapist’s steadiness is a valid foundation that has
supported therapies from the most traditional to the most radical, it
does reach a point of diminishing returns. At the moment of the crunch
in the therapy, as in the moments of transition in the parent–infant
interaction, the destabilization must be a mutual process if key
development and change of structure is to take place. As the
bifurcation model suggests, when the destabilization of an existing
state has reached a threshold, it will go to some new state. Whether
that new state is a richer, more complex, and more appropriate
foundation for further development, or is the less advantageous choice
in the sense of narrowing through toxic adaptation, may depend on
whether the partner in this self-organizing system biases it in one
direction or the other. The more toxic adaptation can stem from an
interactional partner who reacts as if the destabilization were toxic.
That is, if the therapist’s (or parent’s) primary aim is to reduce his
own destabilization and its accompanying anxiety as if it were toxic
and intolerable, the partner’s aim and choice will be biased in the
same direction. If the therapist can stay connected with his own and
with the patient’s destabilization and can bias his own subsequent
state choice toward openness and affective authenticity, then the
patient’s will be similarly biased. On the other hand, if the patient
feels the freezing or the pretense of the therapist at these critical
moments, the work of the therapy cannot proceed well.

Neither therapists nor patients choose the moments or kinds of
destabilizations encountered, but we do have some latitude in working
with our own affective destabilization and with the patients’. If we
start from a stance of affective presence, then the atmosphere in the
therapy is open and natural. Such a stance does not mean a lack of
stability on our part any more than a parent’s affective presence with
a child implies a lack of stability. It does mean that, when the inevitable
moments of mutual destabilization occur, we will not be in a foreign
 territory and can promote changes in ourselves and in our patients to effect a favorable outcome, greater freedom, and greater integration. There may be times when a therapist may wish, deliberately, to destabilize the patient’s affective organization. The therapist may do this even knowing that he may be placing some strain on the therapeutic alliance. A minor destabilization may occur around such a seemingly innocent question as, “And what else?” The implication of such a question is that the therapist, while validating what has been said, questions whether there isn’t more to be said. This kind of gentle reframing of a patient’s psychic process happens so often as to be virtually unnoticed. Ultimately it signals a new way of being together. In this new mode, the patient is more self-reflective rather than experiencing his affect states as reactions to what is being done to him.

At other times, as for example when there is a suicidal delusion, a much more radical confrontation and reframing may be called for. How we go about destabilizing such entrenched pathological processes is an art form in itself, but it is a form that can be facilitated by a mixture of empathy built on specificity of connection between two affect systems, combined with a contextual breadth built on our own disciplined training, self-analysis, and clinical experience.

I recall vividly the case of a young woman with a history of sexual abuse. She had become convinced that she was lethal and that the only way to protect the people she loved was to kill herself so that her lethal influence would be removed. She felt that she was so contaminated and soiled by the abuse—and, more important, by her acquiescence to that abuse—that anyone who was close to her would become contaminated and endangered by her filth. In her first hospitalization we tried to help her understand this delusion and its roots, and to point out the positive healthy side of her relationships. But the primary result of that intervention was that she felt profoundly misunderstood and told us we were wasting our time because she would kill herself as soon as we discharged her. She kept her promise and ingested a more than lethal dose the day after she was discharged. It was only by an improbable stroke of luck that she was found and brought to an ER in time to be saved.

Readmitted to our unit after the necessary medical treatment, she repeated her deep belief and told us we were wasting her time and ours—the next attempt would not fail. We began treatment by
following the same old course of trying to ameliorate the delusion, but, as discharge was nearing and she remained unchanged, our panic grew and we had to rearrange our own inner organization. We took a different tack. We agreed with her that we did not have the power to protect her from her own suicidality. We told her we would try to further her aim of saving the others by having first a family meeting so that people could be reassured that they had done their best for her. Her family would be able to go on, with a deep sense of loss, but free from guilt or responsibility. We also told her how stupid we had been in not taking her at her word. This radical approach was complex and specifically addressed her concerns. She was shocked when she first heard it. After the family meeting where we told the family that we could not save her but could try to relieve the family of their heavy burden of guilt and responsibility, she seemed to experience some relief from her core obsessional delusion. She was safely discharged and went on with a new direction in her life. We were negotiating with our hearts in our throats, as she was. In some unique way, our affective state met her affective state.

Longstanding affective-relational-perceptual-ideational patterns have been viewed as structural because of their durability. Earlier models of structure were so concrete that durability was inevitably confused with, and equated to, immutability. Now that we see structural stability as a matter of dynamics repeated over and over again, we can separate durability from immutability. We see that beneficial change within self-organizing systems can be brought about by destabilizing old states and by biasing the creation of new states through the negotiation process. The key to the mutability lies in the specificity of the two affective structures. A door that has been locked for eons, that is, been unquestionably durable, nevertheless may be opened, that is, made mutable in an instant, if a key that fits can be found. But the lock or knot or impasse is not simple. We know that at the very least the key must embrace both sides of the host of ambivalent polarities that make up any patient’s affect system.

The therapeutic process involves the specificity of being known and knowing the other, albeit incompletely. It is related to a level of affective communication and atunement that is always imperfect and always changing but that nevertheless, at certain key moments, feels like the perfect fit, a fit that can stabilize and destabilize us at the same moment, paving the way for new structure to emerge.
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