8 Mindfulness, Metacommunication, and Affect Regulation in Psychoanalytic Treatment

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ROMY READING

Both Western psychotherapy and Buddhism share the goals of fostering transformation and alleviating suffering. These common goals have inspired a long-standing dialogue between the two traditions. In this chapter, we focus specifically on the cross-fertilization that is beginning to take place between Buddhism and contemporary psychoanalytic practice. In the 1950s and 1960s, some psychoanalysts were inspired by a flurry of interest in Buddhism, especially as seen in the works of Erich Fromm and Karen Horney. However, until recent years, this interest had not had a significant impact on mainstream psychoanalysis. In the last decade, however, the dialogue between psychoanalysis and Buddhism has accelerated, resulting in an exchange of wisdom that has begun to transform both traditions (Epstein, 1995; Rubin, 1996; Safran, 2003, 2006). In this chapter, we will focus specifically on the use of mindfulness practice as a tool for enhancing the therapist's ability to work constructively with the therapeutic relationship from a contemporary psychoanalytic perspective.

Mindfulness, as described in Buddhist technical treatises dating as far back as the third century B.C.E., can be conceptualized as the process of locating and directing one's awareness to the present moment as it unfolds. Essential to the development of this awareness is the simultaneous cultivation of self-acceptance and nonjudgment. The goal of mindfulness is to guide one to deautomate habitual ways of thinking, relating, and behaving. In what follows we examine a form of dialogical mindfulness practice, referred to as therapeutic metacommunication. We also provide background from theoretical developments in affect regulation. Therapeutic metacommunication is conceptualized as a form of mindfulness in action through which the therapist engages the patient in an ongoing collaborative exploration of patterns that unfold in the therapeutic relationship.

RELATIONAL PATTERNS AND ENACTMENTS

One of the most important changes that have taken place in the psychoanalytic tradition in the last two decades has been the shift from a view of the therapist as a neutral observer who stands outside of the relational field to a view in which the therapist is seen as an inextricable participant in the co-creation of the clinical situation. According to this paradigm shift, the therapist is an engaged participant whose subjectivity and emotional responsiveness interact with that of the patient, creating an interactional dynamic that constitutes the therapeutic relationship (Aron, 1996; Benjamin, 1988; Mitchell, 1988, 2000; Safran & Muran, 2000). Both the therapist and patient are understood to contribute consciously and unconsciously to the emergent therapeutic relationship. Everything that takes place in the therapy session is thus viewed as an ongoing co-creation of both participants in the therapeutic dyad. An ongoing exploration of this co-constructed reality and the interactional patterns of which it consists is considered essential to the therapeutic process.

All relational patterns that unfold in the therapeutic relationship can be understood as expressions of the patient's and therapist's unique personal histories, conflicts, and ways of relating to the world. In contemporary psychoanalytic theory, these relational patterns are conceptualized as involving unconscious contributions by both therapist and patient, and are termed enactments (e.g., Aron, 1996; Jacobs, 1991). An individual's generalized expectations about self-other interactions, known as relational schemas, shape his or her interpersonal perceptions. These relational schemas and perceptions guide, both consciously and unconsciously, the interpersonal strategies, actions, and interactions that unfold between the individual and other people. Each person's schemas can elicit varied reactions from the other, depending on the other's own unique relational schemas. For example, dominance may evoke submis-
siveness in one person and anger in another, while hostility may elicit compliance in one individual and further hostility in another. The interactional outcome is an emergent process that depends upon the conscious and unconscious contributions of both individuals in the moment.

In contemporary psychoanalytic thinking two assumptions can be made concerning these enactments. First, the therapist and patient themselves will inevitably become unconsciously embedded in enactments that reflect their unique characteristics. Second, the characteristic relational patterns that emerge between the patient and therapist may in some ways reflect patterns that emerge for the patient in his or her interpersonal relations outside of therapy. Although these enactments can obstruct the therapeutic process if they remain unexamined, they can also serve as fertile soil out of which constructive therapeutic process can grow. By working through therapeutic enactments in a mindful way, therapists and patients can discover internal processes and relational patterns that are problematic for patients and provide them with new, constructive relational experiences that modify their maladaptive relational schemas.

The process of disembedding from enactments involves an ongoing collaborative exploration between the therapist and the patient. To the extent that the therapist can collaborate in the process of becoming aware of and disembedding from the enactment, the patient will be able to engage in a new type of relational experience. Over time new relational experiences of this type can begin to modify maladaptive relational schemas or beliefs that shape the patient’s interpersonal relationships outside of therapy. In addition, this process of collaboratively exploring enactments can help patients develop mindfulness skills that will be useful in deautomating their own unconscious self-defeating patterns in relationships with others. This is particularly important, since as noted earlier, there will be both similarities and differences between the therapeutic relationship and other relationships in the patient’s life. The cultivation of relational mindfulness skills through the ongoing, collaborative exploration of the therapeutic relationship thus helps patients to cultivate a generalizable skill that they can use in their everyday lives.

MINDFULNESS AND DISEMBEDDING

When therapist and patient become embedded in an enactment, their contributions to the process exist outside of or on the fringes of aware-

ness. The therapist’s task is to engage the patient in a collaborative process of exploring these enactments in an attempt to discover how each of them is contributing. Through a type of mindful investigation, enactments can gradually be transformed into opportunities for awakening. For both patient and therapist, participation in an enactment is partially maintained by a disowning or dissociation of aspects of self-experience that are threatening or unacceptable. For example, the therapist who is embedded in a power struggle with his patient will have difficulty stepping outside of this struggle if he has difficulty acknowledging that he feels threatened or competitive. The therapist who is being critical or abusive toward her patients will have difficulty stepping outside of this enactment if she has difficulty acknowledging that she is feeling angry. It is for this reason that the skill of mindfulness becomes invaluable in facilitating the process of disembedding.

In the Buddhist tradition, the goal of mindfulness practice is to ultimately realize that all phenomena are inherently “empty” of any intrinsic, separate existence. In the psychoanalytic practice the emphasis is not on coming to experience the intrinsic emptiness of all phenomena but rather to become aware of dissociated feelings and actions and to use them as an important source of information. Two objectives can be articulated. First, mindfulness practice can enable the therapist to cultivate a sense of internal space by decreasing his or her attachment to any particular feeling. Within this opening of internal space new possibilities for potentially constructive therapeutic work emerge. We discuss this notion of internal space in greater detail later. Second, mindfulness allows therapists to refine their attentional skills so that awareness of their inner experience and their contributions to enactments can serve as an important source of information for the therapeutic process.

As stated previously mindfulness involves learning to locate and direct one’s attention in an accepting and nonjudgmental fashion to one’s thoughts, feelings, fantasies, and actions as they emerge in the present moment. Although it is recognized as inevitable that at times individuals who are attending to their experience mindfuly will feel critical of their experience or themselves, the practice of mindfulness involves taking this judgment itself as the focus of awareness rather than trying to change it or avoid it. In this way the judgment itself begins to lose some of its potency. Through this process, a type of “letting go” or surrender begins to emerge for the therapist, and the experience of internal constriction associated with the need to dissociate experiences is replaced by an experience of internal space. Mindfulness enables therapists to cultivate a state of mind that allows them to work with their own internal experience so as to negotiate their way from a place devoid of possi-
abilities for constructive therapeutic work to one in which acceptance and surrender allow for new possibilities to emerge (Safran & Muran, 2000; Safran 2003, 2006).

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METACOMMUNICATION: MINDFULNESS IN ACTION

As previously indicated, a key tool for applying mindfulness practice to the collaborative exploration of enactments consists of therapeutic metacommunication—communicating about the implicit communication that is being enacted in the therapeutic relationship. The patient may, for example, be explicitly saying to the therapist: “Nobody is there for me” and implicitly saying, “You’re not there for me.” A therapist may explicitly be saying to the patient, “What’s going on in our relationship is similar to what goes on for you in your relationships with other people” and implicitly be saying, “The problem is yours, not mine.” Metacommunication is a type of mindfulness in action that involves investigating the nature and meaning of these implicit communications. A collaborative effort is made to bring an ongoing awareness to the interaction between the therapist and patient as it unfolds in the moment.

Essential to metacommunication is the therapist’s ability to become as grounded as possible in her immediate experience of her own feelings or some aspect of the therapeutic relationship. Metacommunication requires that the therapist use her own feelings as a point of departure for the collaborative exploration. Various forms of metacommunication are possible. The therapist may, for example, provide the patient with feedback about the impact that the patient is having on her, for example, “I feel cautious with you . . . as if I am walking on eggshells.” Or “I feel like it’s difficult to really make contact with you. On the other hand, the things you’re talking about really seem important. But on the other, there is a subtle level at which it’s difficult for me to really feel you.” Or “I feel judged by you.” All these expressions of feedback can serve to open up an exploration of the patient’s inner experience. For example, the therapist can add, “Does this feedback make any sense to you? Do you have any awareness of judging me?” In some cases the patient will answer yes and further exploration can lead to a deeper understanding of his or her inner experience. In other cases, the patient will answer no. In such cases, it is possible that the therapist’s feeling of being judged reflects her own contribution more than the patient’s. Or alternatively, the patient may be judging the therapist but unable to become aware of this in the moment. As long as this feedback is offered in a tentative and exploratory fashion, however, no harm will be done, and when the time is ripe the therapist will be able to metacommunicate in a fashion that facilitates greater awareness in the patient. It can also be beneficial for the therapist to point directly to the specific instances of the patient’s elicitings the actions. “I feel dismissed or closed out by you, and I think that may be because you tend to not pause or reflect in a way that would indicate that you are really considering what I am saying.” All of these statements are intended to bring an ongoing awareness to the interaction as it unfolds in the moment. Below we outline some general principles of metacommunication. For a more detailed description the reader is referred to Safran and Muran (2000).

PRINCIPLES OF METACOMMUNICATION

1. Explore with skillful tentativeness and emphasize one's own subjectivity. The communication by the therapist should be exploratory. Rather than aiming to convey an objective tone, therapists should emphasize their own subjectivity. This approach is very much in accord with the understanding in contemporary psychoanalytic thinking that the therapist's presence is not meant to be authoritative but instead collaborative. It is also vital to stress that the message at both the explicit and implicit levels should be one of inviting patients to engage in a collaborative attempt to understand what is taking place. Emphasizing the subjectivity of the therapist's perception encourages patients to use his or her observations as a stimulus for self-exploration rather than feeling compelled to react to either positive or negative authoritative statements.

2. Do not assume a parallel with other relationships. Although the process of metacommunication serves as a means for disembedding from enactments and, over time, modifies maladaptive relational schemas about self-other interactions, therapists should be concerned about prematurely attempting to establish a link between the configuration that is being enacted in the therapeutic relationship and other relationships in the patient's life. Although such parallels can be illuminating in some contexts, they can also be experienced by patients as blaming. In keeping with the principles of mindfulness, the focus should be on exploring the patients' internal experiences in a nuanced fashion, as they emerge in the moment.

3. Ground all formulations in awareness of your own feelings and accept responsibility for your own contributions. Therapists should always
begin by attempting to reflect on their own emergent emotions. Failure to do so may increase the level of distortion that stems from unconscious elements. Taking responsibility for one’s own contributions to the interaction is vital. Since each participant is contributing to the interaction in ways of which they are unaware, it is essential to continually attempt to clarify the nature of the contribution. The process of explicitly acknowledging responsibility for one’s contributions can be a potent intervention at times. First, the process can help patients to also become aware of unconscious or semiconscious feelings that they may have difficulty articulating. For example, acknowledging that one has been critical can help patients to articulate their feelings of hurt and resentment. Second, by validating the patient’s perception of the therapist’s actions, the therapist is able to reduce his or her own need for defensiveness.

4. Start where you are. The ability to remain anchored in the moment, which is central to mindfulness practice, will greatly serve the process of metacommunication. Collaborative exploration of the therapeutic relationship should take into account the feelings, intuitions, and observations that are emerging for the therapist and patient in the moment. It is critical to understand that what was true in one session may not be true in the next and what was true in one moment may change in the next moment. For example, while a therapist may be able to adopt an empathic response toward an aggressive patient in one moment, another moment may lead the therapist to a space in which she cannot feel empathic. Instead, the therapist must begin by fully accepting and working with her own feelings and subjective reactions to the patient’s expression of aggression as it occurs in the moment. From there further collaborative understanding can follow.

5. Evaluate and explore patients’ responses to interventions. Patients’ responsiveness to interventions must continuously be monitored and explored. It is important to understand if patients are using the therapist’s intervention as a stimulus for further investigation or if they are responding in a way that is inhibiting further understanding. Do they respond in a minimal fashion without elaboration? Do they not respond at all? Do they respond in a defensive or self-justifying fashion? Do they agree too readily in what appears to be an attempt to be a “good” patient? It is essential that therapists mindfully attend to their own subtle intuitions about the quality of a patient’s responsiveness, and carefully acknowledge any sensation linked to a patient’s response. For example, the therapist may feel at some level that the patient has an ambivalent response to an intervention, even though the therapist may have difficulty articulating what cues these feelings are based on. If and when an intervention fails to deepen exploration or in fact further inhibits such exploration, it is vital that the therapist explore the way in which the patient has experienced the intervention. Did the patient experience the therapist’s intervention as critical, blaming, or accusatory? Did he or she experience it as domineering, demanding, or manipulative? Over time, this type of collaborative exploration can help to articulate the nature of the enactments that are taking place. In addition, these very explorations can serve to guide patients toward understanding their characteristic ways of construing interpersonal relationships and gradually lead to a fleshing out of their unique relational schemas.

6. Collaborative exploration of the therapeutic relationship and disembedding take place at the same time. A clear formulation of what is occurring in the context of the enactment is not a necessary prerequisite to initiating the metacommunication process. In fact the very process of articulating one’s own perceptions and feelings as they arise in the moment can lead to a more authentic formulation that will be grounded in a collaboration with the patient. Moreover, the process of telling patients about an aspect of one’s experience that one is in conflict over can open the internal space so that the therapist is free to see the situation with more clarity. For example, a therapist who is feeling resentful toward a patient who does not respect his boundaries judges himself harshly for feeling resentful, dissociates his negative feelings, and experiences a collapse of internal space that prevents him from responding creatively to the situation. In this situation, it might be helpful for the therapist to say something like “I feel anxious about saying this because I’m afraid of hurting your feelings, but I think I’ve been feeling a bit irritated because it feels like my boundaries are being pushed against.” The process of putting what feels unsayable into words begins to reopen the therapist’s internal space.

7. Remember that an attempt to explore what is taking place in the therapeutic relationship can function as a new cycle of an ongoing unconscious enactment. Any metacommunication can itself be an enactment. For example, the therapist may articulate a growing intuition that the patient is withdrawing, and say, “It feels to me like I’m trying to pull teeth.” Perhaps as a result of perceiving the therapist’s unconscious defensive contribution, the patient withdraws even further and the interpersonal dance intensifies, with the therapist escalating his attempts to break through and the patient only becoming more defended. Therefore it is critical to track the quality of patient responsiveness to all interventions and especially to examine their experience of interventions that
have not been facilitative. The therapist must ask, does the intervention deepen the patient's self-exploration or lead to defensiveness or compliance? The process of exploring the way in which patients experience interventions that are not facilitative helps to refine the understanding of the unconscious interpersonal dance that is taking place in the moment.

THE THERAPIST'S MIND AS AN INSTRUMENT OF CHANGE

When metacommunication enables the therapist and patient to disembed from an enactment, it does so not just because the therapist has found the right words, but also because the words reflect the fact that the therapist has managed to enter into the right state of mind. Metacommunication not only helps patients to become aware of their relational patterns, it helps the therapist enter into a therapeutic state of mind by putting into words that which feels unspeakable (Safran & Muran, 2000). To speak about the therapist's state of mind, however, does not do justice to the nondual nature of the mind-body relationship. A more accurate phrase would be the therapist's embodied state of being. The mind is embodied and the patient-therapist interaction, like all other human interactions, involves a process of mutual influence and regulation at a bodily felt level. The heart of the therapeutic process involves affective communication at both conscious and unconscious levels (Safran & Muran, 2000).

In order to understand the significance of this point it is worth taking a brief detour into the realm of emotion theory and research. There is a movement afoot in diverse therapeutic traditions to develop a comprehensive motivational theory grounded in contemporary emotion theory and research (e.g., Greenberg & Safran, 1987; Jones, 1995; Lichtenberg, 1989; Safran & Greenberg, 1991; Spezanno, 1993). Central to this theory is the notion that emotions are biologically wired into the human organism through an evolutionary process and that they play an adaptive role in the survival of the species. Emotions function to safeguard the concerns of the organism (Ekman & Davidson, 1994; Frijda, 1986; Spezanno, 1993). Some of these concerns or goals are biologically programmed (e.g., attachment), while others are learned. Emotions are conceptualized as a form of action disposition information. They provide us with internal feedback about the actions that we are prepared to engage in, as well as information about the self as a biological organism with a particular history in interaction with the environment. As such, they are at the core of subjective and intersubjective meaning.

It is useful to understand the structure underlying the fundamental sequences of social behavior in terms of motivational systems that have been wired into the human species through a process of natural selection. Examples include attachment, exploration, sexual excitement, flight, and aggression (e.g., Bowlby, 1988; Jones, 1995; Spezanno 1993). Emotions function as the subjective readout (or experiential monitor) of which motivational systems or combinations of them are dominant at any given time. These systems become activated in response to the appraisal (which is typically only partially conscious) of various environmental contingencies. For example, anger occurs in response to events experienced as an assault or violation. It informs the individual of his or her organismic preparedness to engage in self-protective behavior. Sadness occurs in response to a loss and organismically prepares one to recover or compensate for what is lost. Fear is evoked by events appraised as dangerous and informs individuals of an organismic preparedness for flight. Emotions can thus be thought of as a type of embodied knowledge.

While emotion provides the individual with a monitor of his or her own action dispositions, the expressive-motor behaviors associated with it provide others with an ongoing readout of these same action dispositions. While this process of reading the other's affect displays can have a conscious element to it, a good deal of it takes place out of awareness, in the same way that other affective appraisals take place. Thus, for example, we may unconsciously appraise the other's aggressive disposition toward us, and in turn feel angry (i.e., be prepared to reciprocate with aggression), without being fully aware of either our own readiness to be aggressive or the cues to which we are responding. Moreover, we may be unconsciously responding to an action disposition that the other may be unaware of. As Parkinson (1995) suggests in his review of the literature on affective communication, "Moment-to-moment reactions to another person's displays are not mediated by any conscious emotional conclusions about what these expressions signify but rather are part of one's skilled and automatized engagement in interpersonal life, and one's ecological attunement to the unfolding dynamic aspects of the situation" (p. 279).

Healthy functioning thereby involves the integration of affective in formation with higher-level cognitive processing in order to act in fashion that is grounded in organismically based need, but not bound by reflexive action (Greenberg & Safran, 1987; Leventhal, 1984; Safran & Greenberg, 1991). Thus, for example, an individual may be aware of his anger at someone but deem it unwise to respond aggressively. Ind
viduals who have difficulty accessing the full range of their emotional experience, however, will be deprived of important information. They may suppress or fail to mobilize a motivational system that may be adaptive in a specific context. For example, the individual who has difficulty experiencing anger may fail to mobilize adaptive aggression. The individual who has difficulty experiencing more vulnerable feelings may fail to fulfill healthy needs for nurturance. A second consequence of the process of dissociating emotional experience is that there may be incongruence between one's actions and subjective experience. Since the activation of a motivational system is not dependent on the conscious experience of the associated emotion, it is not uncommon for people to have only partial awareness of the impact they have on others. Thus, for example, the individual who dissociates feelings of anger may nevertheless act aggressively and evoke aggression in response. This type of incongruent communication can play a major role in psychopathology and in the type of therapeutic enactments discussed previously.

There is growing evidence that a range of psychopathologies involve deficits in the capacity for affect regulation (Schore, 2003). Affect regulation involves tolerating, modulating, and making constructive use of a range of different affective states, including those that are intensely painful or pleasurable, without needing to dissociate them. People initially develop the capacity for affect regulation through their interactions with their attachment figures. As infant researchers have shown, there is an ongoing process of mutual affective regulation between mothers and infants through which both partners influence each other's affective states (Beebe & Lachmann, 2002; Tronick, 1989). In a healthy developmental process there is an optimal balance between interactive regulation and self-regulation. There are periods when the mother and infant are affectively coordinated with one another and periods when they are not. When this process becomes derailed there is an excess of one of the two types of affect regulation (i.e., either an excess of interactive regulation or an excess of self-regulation). Thus for example, the mother who is excessively dependent on emotional contact with her infant will pursue eye contact with him in an attempt to elicit a smile even after he has averted his gaze. Or alternatively, the child who learns that parents respond to her own painful feelings (e.g., anxiety, anger) with catastrophic responses of their own (e.g., panicking or becoming excessively angry) will learn to attempt to regulate her feelings on her own. Without having the experience of learning that these feelings are tolerable within the relationship, however, he or she will never develop the capacity to self-regulate in a healthy fashion and will not be able to learn to use relationships in a healthy fashion to help regulate painful or distressing feelings.

In treatment, therapists' ability to resonate with their patients' more painful emotions and to tolerate the intensely painful and frightening emotions that can be evoked in them during enactments can be transformative for patients in and of itself. This type of containment (to use the psychoanalyst Wilfred Bion's term), in which therapists process emotions evoked in them by patients in a nondefensive way, can be a powerful way of helping them to learn that relationships will not necessarily be destroyed by painful, aggressive, or potentially divisive feelings and that they themselves can survive these feelings. To be able to provide this type of affect regulation or containment for the patient, however, therapists require the capacity to regulate their own difficult or painful feelings in a constructive fashion. Psychoanalysts have always maintained that the therapist's capacity to manage difficult feelings evoked in him or her during the treatment (what are referred to as countertransference feelings) is a critical therapeutic skill. It has been assumed that one develops this capacity through undergoing one's own personal treatment. And to the extent that the capacity for affect regulation develops as a result of healthy developmental experiences (and therapy is conceptualized in part as a healthy developmental experience), this seems reasonable. The cultivation of an ongoing mindfulness practice in combination with the practice of therapeutic metacommunication can, however, play a valuable role in helping therapists to further refine this capacity.

A CLINICAL ILLUSTRATION

We now examine a brief clinical illustration of the process of metacommunication. Since our emphasis here is on clinical process rather than case conceptualization no information is provided about the background or details of the case. The transcript is taken from an early session with a desperate and angrily demanding patient whom we call Silvia.¹

THERAPIST: So this is our second session together, and I am wondering what you're feeling, and whether you have any thoughts or questions after our last session.

SILVIA: I'm not very happy. I'm very frustrated with you, actually. Last time, I came in here, just sat here, and I talked and talked and
talked. And nothing, absolutely nothing. You sat there, the way you are sitting there now, and you didn't really say much of anything, and I—it's angering me because if I'm supposed to come—if I'm going to therapy, if I'm going here and I'm doing this, I want an answer. I can't just talk and talk. And talk and have you say things that lead me in an abstract way. How is this gonna work? I need to know from you how this is going to work? I need a concrete answer. How do I get from where I am now to somewhere else? I need a way to go. I don't know how to go. I've been in therapy for 2 years and nothing seems to be helping. And you're not helping either. So, it's like, what do I do?

THERAPIST: OK, so you know, I'm hearing that you're not happy about our last session and that you're feeling frustrated and also, if I understand correctly, that you'd like to hear more from me as to what—about how the therapy works...

SILVIA: How do you do work? How do you do what you do? How is this supposed to help me? How do I fix what's going on?

THERAPIST: OK, I'll try to answer that. But before I say anything, I want to say that I have some concern about whether or not whatever I'm going to say is what you're really wanting. But I'll do my best. OK. you have a funny look on your face. 

SILVIA: I'm not sure why you're concerned about that. Isn't that your job? To tell me how things are supposed to go... I'm confused then.

Silvia begins the session by expressing her anger and frustration with the way things have been going and by pressuring the therapist to provide her with an explanation of how therapy is going to help her. The therapist metacommunicates his concern that it is going to be difficult to satisfy her and then, picking up on her exasperated look, begins to explore her reaction to his metacommunication. Although this first attempt at metacommunication has not yet led to a positive shift in the quality of the therapeutic relationship, it has initiated the process of helping the therapist to enter into a more therapeutic state of mind. By attending to his experience rather than responding to the pressure and discomfort he feels without awareness, and by putting his intuitions into words, he begins to regulate his own affect and is able to avoid responding in an overly defensive way.

THERAPIST: Yeah, I mean it is my job to do my best to help you and try and answer your questions, yeah, but there is something about it's a bit difficult for me to put into words... but something about the intensity with which you are asking for things that makes me a little bit... which leads me to question my ability to give you the answer that you're wanting. But I'll try... OK? I sically as I see it, the way in which therapy works is that the two of us will work together to explore things that you may not be completely aware of... ways that you may see things that are so defeating or ways in which you are dealing with your feelings... are self-defeating, or ways in which... you're shaking your head.

SILVIA: I'm not defeating myself. I don't defeat myself. I don't understand how coming in here and working on it together is gonna help. Aren't you—isn't it supposed to be that I say what's going on and you tell me an answer—give me an answer? Isn't that the way it usually works? You ask a question, you get an answer. I don't understand what you're trying to do that would help. I don't think I'm defeating myself.

THERAPIST: Um-hmm.

SILVIA: I don't think I'm defeating myself at all.

THERAPIST: Um-hmm.

SILVIA: I think I come in here for answers and you're not giving them to me.

THERAPIST: Um-hmm. I'll certainly give you answers to the extent that I have them. But also some of it will have to come out of the two of us really exploring things together.

SILVIA: Yeah, that's too abstract for me. I need something concrete. I need to know how to get from point A to point B.

THERAPIST: Um-hmm.

SILVIA: And if I'm just gonna sit here and get this abstract stuff... kind of wasting my time, isn't it? It's kind of a waste of my time. That's what the past 2 years have been with other people. It's just a waste of my time if I just sit and get things in the abstract.

THERAPIST: Um-hmm, yeah, you know I'm trying to think if there is a way that I can be more concrete than I am right now. Um, let me give you an example, OK?
SILVIA: OK, that's concrete.

THERAPIST: Even right now, let's try to take a look at what's going on between the two of us. You obviously, you want an answer, and I understand that you want an answer, and I want to give you what you need. But I think there is something about the—just try to understand what's going on for me—the there's something about the intensity with which you're asking... the pressure where I'm supposed to produce something, that makes it difficult for me to...

SILVIA: Isn't it your job? To produce something... to give me an answer? Isn't that your job?

THERAPIST: Well my job is to help you. But there's something about what's going on between the two of us right now that's making it difficult for me to really give you what you're wanting or needing.

SILVIA: Aren't you asking me to perform too? Aren't you asking me to give you stuff too?

THERAPIST: Tell me more about that. Does it seem...

SILVIA: Aren't you asking me to tell you what's going on with me and articulate what's going on with me? So I'm being asked to perform too? Aren't I?

THERAPIST: I'm wondering if you felt criticized by what I said just now.

SILVIA: Of course I did. I felt like you're blaming me. Like I came in here and I was trying to say how I felt, and trying to say what I wanted from you... and needed from you and it comes right back at me.

THERAPIST: OK... I need to think about that a little bit. I don't think it was my intention to blame you... but maybe there was a way in which I was responding out of feeling pressured, and maybe feeling... feeling a little bit blamed for not giving you what you want. So that in turn I was kind of blaming you. So it's kind of like passing a hot potato back and forth. You know... like you're saying I'm not doing my job, and I'm saying you're not doing your job. Does that make any sense to you?

SILVIA: Yeah, a little, yeah.

THERAPIST: OK... so if that is what's going on between the two of us then... I'm not exactly sure how we're going to get past this... but I think the two of us being able to agree that that is what's going on is a start... right? And, I'm willing to work with you in order to help the two of us find a way to get past this point. Right? And my sense is that would be an important first step for us. OK?
sibility for his own negative feelings, the therapist begins the process of detoxifying the cycle of blame and counterblame and helps Silvia begin to tolerate and acknowledge her own feelings of anger and resentment. She thus has less of a need to see the hostility as originating exclusively from the therapist.

If this process continues over the course of treatment, Silvia will become less likely to experience the therapist as persecuting or depriving, and better able to acknowledge underlying feelings of despair, and eventually feelings of vulnerability and need as well. These more vulnerable underlying feelings are then able to actualize their adaptive potential by eliciting comfort and nurturance from the other. This in turn will make it easier for the therapist to genuinely empathize with Silvia and to provide the support and nurturance she so desperately needs. In this fashion a process of positive mutual affective regulation takes over time in which the therapist is able to help regulate Silvia's feelings by regulating his own feelings. As Silvia internalizes this constructive relational experience, she begins to develop new type of implicit relational knowing (Lyons-Ruth, 1998) that allows her to become better at using the other to help her regulate her affective experience and better at regulating her own affective experience as well.

CONCLUSION

There is a growing recognition in diverse therapeutic traditions that the relational and nonverbal aspects of the therapeutic process are as important as the verbal aspects. This is particularly true within contemporary psychoanalytic thinking. Building upon insights emerging from mother-infant developmental research, we have proposed a model of change in which the process of mutual affective regulation between therapist and patient lies at the core of the change process. Emotional dysregulation plays an important role in many forms of psychopathology, and the therapist's capacity to regulate his or her own emotions during therapeutic enactments and difficult therapeutic moments can be critical in the process of helping patients to learn to regulate their emotions more constructively, both through the use of the other and through self-regulation skills that emerge out of the process of mutual regulations between therapist and patient.

Mindfulness meditation provides a tool that therapists can use to help them develop a greater capacity to regulate their own affect so that they are better able to serve as surrogate affect regulators for their patients during therapeutic enactments. The internal skills acquired through mindfulness practice can also help therapists develop the skills to metacommunicate with their patients during enactments in order to help them both disembed from destructive relational scenarios, thereby providing patients with new relational experiences that will modify their internal models of self-other relationships. This process leads to a change in the patient's implicit relational knowing (Lyons-Ruth, 1998) about self-other relationships.

NOTE


REFERENCES

Safran, J. D. (2003). Psychoanalysis and Buddhism as cultural institutions. In J. D. Safran...
As I looked at the picture, I could see dark storm clouds, rain, and lightning framing the edges, with several objects floating, suspended under the dark clouds in a sea of agitation. A boy of 10, accompanied by his mother (details changed to protect client privacy), was showing me his drawing about how “worry” overshadowed his life. The picture was devoid of human presence, except for two large hands stretching up from the bottom, straining, yearning for help but achingly empty. As the boy talked about his drawing, his agitation was almost palpable in the air, with his mother slumped in her chair, defeated, overcome with discouragement.

Amidst the voices of agitation and discouragement, I sensed other “voices” present in our conversation on the periphery of my awareness. As I focused on my breath and sank more deeply into the present moment, I began to notice echoes and resonances of more hopeful and peaceful voices (Bakhtin, 1984) that were absent, yet implicit in the conversational stream. I began to ask questions about these alternate voices in the flow of discussion; the boy sat back in his chair attentively as his mother began to sit up. After I described mindfulness to them as a way of decentering oneself from one’s thoughts and outlined the practices that nurture this way of positioning oneself in the world, the boy was eager to “give it a try.” After they had meditated together for a short time, the mother commented that this was similar to what they had learned in their first yoga class last week. Smiling,