Hellenic Journal of Psychology, Vol. 6 (2009), pp. 292-309

AFFECT REGULATION, METACOMMUNICATION AND MINDFULNESS IN ACTION

Jeremy D. Safran & Julia N. Belotserkovsky
New School for Social Research, New York, USA

Abstract: Deficits in affect regulation skills play an important role in many forms of psychopathology. Affect regulation involves tolerating, moderating and making constructive use of a range of affective states, including those that are intensely painful or pleasurable, without needing to dissociate them. In this article, we discuss the role that the therapist's ability to regulate his or her own affective experience can play in helping patients to regulate their own affective experience. The therapeutic encounter involves an on ongoing process of mutual affective regulation between therapist and patients through which both partners influence each other's affective experience. Patients with affect regulation problems are likely to evoke intense feelings in their therapist, and the therapist's ability to work constructively with their own internal experience is an important therapeutic skill. We explore the role that both mindfulness practice and therapeutic metacommunication (i.e., the process of collaboratively exploring what is taking place between therapist and patient in a reflective and nonjudgmental fashion) can play in facilitating the process of affect regulation in both therapist and patient.

Key words: Affect regulation, Metacommunication, Mindfulness, Psychopathology.

INTRODUCTION

There is growing evidence that various forms of psychopathology involve deficits in one's capacity to regulate affect (Schore, 2003). Affect regulation encompasses 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. Enhancing one's alertness to his or her emotions and actions provides the individual with information about his or her habitual patterns of thinking, relating, and behaving. The individual can then utilize this knowledge in a benefi-

Address: Jeremy D. Safran, Psychology Department, New School for Social Research, 80 Fifth Ave., New York, NY 10011, USA. E-mail: safranj@newschool.edu

cial way to successfully regulate ongoing emotional responses and to choose more advantageous actions. One's ability to regulate affect is therefore predicated on high level of awareness of one's feelings, motivations and behaviors, which endows the individual with greater capacity to pay attention to his or her needs and to function in a way that is responsive to them, without needing to act impulsively. Therefore, an improved ability to modulate and integrate one's emotional responses leads to healthier functioning and can be viewed as one of the central goals of the therapeutic process. In this article we will explore the role of the therapist in helping the patient to achieve enhanced capacity of affect regulation from theoretical as well as practical viewpoints.

AFFECT REGULATION

Multiple therapeutic traditions have made attempts 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; Spezzano, 1993). The view of emotions as biologically wired into the human organism through an evolutionary process is central to this theory. Emotions are understood to play an adaptive role in the survival of the species and to safeguard the concerns and goals of the organism (Ekman & Davidson, 1994; Frijda, 1986; Spezzano, 1993). While some of these concerns such as the goal of maintaining proximity to the attachment figure or the goal of reproduction are biologically programmed and facilitate the survival of the species, many others are acquired through development. Importantly, emotions provide us with internal feedback about the actions that we contemplate or are about to undertake. They also inform us about the self as a biological organism, with its own unique history of interactions with its surroundings. By doing so, they operate at the core of subjective and intersubjective perceptions, and allow us to create meaning based on these perceptions.

Evolutionary processes have led to the development of a variety of hardwired human emotions. Human species have developed motivational systems through the process of natural selection, and many of the social behaviors that human organisms engage in are predetermined by them. Examples of such behaviors include attachment, aggression, exploration, sexual excitement, and flight (Bowlby, 1988; Jones, 1995; Spezzano, 1993). Motivational systems or combinations of them that prevail within the moment determine the subjectively experienced instantaneous emotion. Appraisal of various environmental contingencies, at both conscious and unconscious levels, activates these systems. For example, anger occurs in response to

events experienced as a violation or attack. It informs the individual of his or her organismic preparedness to engage in self-protective behavior. Sadness, on the other hand, arises in response to a loss and prepares the organism to recover or compensate for what is lost. Events appraised as dangerous elicit fear, which informs the individual of the bodily readiness for flight. Emotions, therefore, can be thought of as a form of *embodied knowledge*.

The individual's emotional responses can also be viewed as a monitor of his or her own action dispositions. The expressive-motor behaviors associated with the emotions experienced in the moment serve as the readout of these same action dispositions to others. It is important to realize that, to a large extent, the process of interpreting the other's affective displays takes place out of awareness, similarly to many other affective appraisals. For example, when one experiences anger, it might be due to the fact that he or she unconsciously appraised the other to have an aggressive disposition in the moment. As a result, on the bodily level, the individual is now prepared to reciprocate with aggression. However, one may be unaware of either the signals from the other to which he or she is responding or of one's own readiness to be aggressive in return. Another level of complexity is added to this interplay by the fact that the other may be unaware of his own action disposition or of eliciting a spiteful response. In his review of the literature on affective communication, Parkinson (1995) noted: «Moment-by-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 is associated with the successful integration of affective information with higher level cognitive processing. The ability to do so provides one with the capacity to attend to his/her organismically based needs and to act in keeping with them without being enslaved by his or her reflexive action (Greenberg & Safran, 1987; Leventhal, 1984; Safran & Greenberg, 1991). For example, if one is aware of the resentment he feels towards the other, but is capable of not acting on his anger, as he considers it unproductive to do so, he is no longer bound by his automatic response. However, if he cannot genuinely access the full range of his emotional experience, he will lack important information, which might lead to suppression of the motivational system that would in actuality be highly adaptive. Thus, the individual who has difficulty experiencing anger, and is therefore unaware of his aggressive feelings, will not be able to utilize aggression in an adaptive fashion. Similarly, it will be hard for one to obtain nurturance if he or she has difficulty experiencing and expressing vulnerable feelings associated with dependency.

Another problematic consequence of lack of awareness of one's own emotional experience is that it can lead to incongruence between one's actions and one's subjective experience. Since the activation of the individual's motivational system will be inconsistent with his/her conscious experience of the emotion connected to this experience, the individual might have only partial awareness of the ways in which s/he appears to others and the effect his/her displayed emotions and behaviors might have on them. Thus, for instance, the individual may act aggressively without any awareness of experiencing anger and elicit aggression in response, much to his or her own surprise and dismay. This type of incongruent communication can play a key role in psychopathology as well as in thorny therapeutic exchanges.

On the basis of these theoretical considerations, we can posit that psychological health is associated with a high level of congruence between the individual's actions and subjective experience associated with these actions. Hence, achieving better accord between the patient's emotions, motivations and behaviors is one of the major objectives of the clinical process. The goal of the therapist is to help the patient gain greater awareness of the affective states associated with actions in order to facilitate constructive use of this affective information. Before we discuss the therapist's contribution to the patient's growth in this direction, it is important to carefully consider the mechanism of affect regulation itself.

Affect regulation mechanism

Humans initially develop the capacity for affect regulation through interactions with their attachment figures. Infant researchers have shown that 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). Healthy development is achieved through an optimal balance between interactive regulation and self-regulation. Inevitably, in course of development, there are moments when the mother and the infant are affectively coordinated with each other and moments when they are misattuned. When the optimal balance is not achieved, and this process is disrupted, there is an excess of either external regulation in the child's interpersonal exchanges or of his or her self-regulation. For example, if the child learns that parents respond to his painful feelings, such as anger or anxiety, in a catastrophic manner, such as panic or anger, he will eventually learn to regulate his feelings without involving the parents in this process. This will lead to excessive self-regulation. Conversely, when the mother is overly dependent on emotional contact with her infant, she might pursue eye contact with him in an attempt to elicit a smile, even after the infant has averted his

gaze. This represents excessive interactive regulation. Without having learned that painful feelings are tolerable within the relationship or, conversely, that regulation provided by the parent will not be intrusive and burdensome, the child will be unable to develop the capacity for effective self-regulation. Therefore he or she will not learn to regulate distressing feelings within relationships or to constructively utilize relationships in the ways which would help him or her to regulate affect. These deficits will predispose the individual to utilizing habitually maladaptive responses leading to dissatisfying interpersonal experiences. Therefore one of the main objectives of therapeutic exchange is to identify and ultimately modify the patient's non-constructive patterns of relating.

Mutuality, relational schemas, and enactments

The shift from a view of the therapist as one who functions as an unbiased observer outside of the relational field, to the view in which the therapist is seen as a central participant in the co-creation of the clinical situation represents one of the most significant changes that have taken place in psychoanalytic thinking in the last two decades. Within this paradigm, the therapist is viewed as 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). Therefore, everything that occurs in the session becomes a co-creation of two subjective individuals in the dyad. The individual's relational patterns manifest themselves through expressions of his or her personality and through his or her habitual ways of relating to the other. Each individual enters every clinical situation with his or her own pre-conceived notions and generalized expectations about self-other interactions. These generalized expectations are termed *relational schemas*.

Each individual's relational schemas shape his/her perceptions of the unfolding exchanges in the therapeutic relationship. As these relational schemas operate on both conscious and unconscious levels, they shape the interpersonal strategies, actions and interactions that both the therapist and the patient choose, consciously and unconsciously, in their exchanges. It is understood that through manifestations of their unique relational patterns, both the therapist and the patient contribute consciously and unconsciously to the co-created clinical situation. These affective and behavioral contributions to the process are termed *enactments* in contemporary psychoanalytic theory (Aron, 1996; Jacobs, 1991). An enactment takes place when the individual engages in a behavioral and affective interplay with the other without full awareness of the underlying motivations guiding this ongoing exchange.

Central to the notion of an enactment is the understanding that one's interpersonal strategies can elicit varied responses from others which, in turn, are mediated by others' relational schemas. For example, hostility may elicit obedience in one individual and intensify opposition in another, while dominance may draw out submissiveness in one person and wrath in someone else. The outcome of each interaction is a unique interplay of the relational schemas and enactments of both participants, emerging within the moment of the interaction.

For both parties, participating in an enactment is in part perpetuated by a disowning of their respective roles in it. This occurs through the mechanism of dissociating the aspects of self-experience that are threatening or intolerable. To illustrate this point, one can think of the therapist embedded in a power struggle with his patient: if it is hard for the therapist to acknowledge his own feelings of competitiveness or of being threatened, disembedding from this struggle will be difficult. Alternatively, it will be hard for therapists who are being offensive towards their patients to disengage from such enactments if they cannot acknowledge their own feelings of anger.

Thus, disembedding from an enactment requires that therapists become aware of their contribution to it as well as attentive to the difficulties they might have owning this contribution and disengaging from it. It follows that the therapists' clear understanding of their role in an enactment as well as their ability to use their affective response constructively is critical in helping the patient to ultimately gain awareness of his or her respective role in the exchange.

Mindfulness and affect regulation in the therapist and in the patient

As stated above, the goal of the therapist is to engage the patient in a joint exploration of the moment-to-moment interactions unfolding in treatment, their affective responses associated with these interactions and their respective contributions to them. To be able to undertake such an exploration, the therapist must have the capacity to tolerate the intensely painful and frightening emotions that the patient can elicit in him or her. As the therapist provides containment for the patient's painful emotions, the patient learns that relationships will not necessarily be destroyed by unpleasant, aggressive or conflict-ridden feelings. Vicariously, the patient also begins to realize that s/he, in turn, can tolerate these difficult affective states.

Clearly, containing feelings which are difficult to tolerate can be a challenging task for the therapist. To provide containment for the patient, the therapist needs to process the turbulent feelings that the patient evokes in him or her in a non-

defensive manner. To do this, the therapist must be able to efficiently regulate his or her own painful emotional experiences.

We have argued that mindfulness training can play an important role in helping therapists to develop these abilities (Safran & Muran, 2000). Mindfulness training involves directing one's attention in order to become aware of thoughts, feelings, fantasies or actions as they take place in the present moment. The goal is for the therapist to become aware of his or her dissociated feelings and actions and to use them as an important source of information. To gain this knowledge, the therapist should start where *he or she is*. The ability to remain anchored in the moment is central to this task. The therapist should examine his or her emergent feelings, intuitions and observations within the therapeutic relationship. Possessing such awareness will facilitate better affect regulation in the therapist through more than one mechanism. First, awareness of a certain feeling leads to a weakening of attachment to it, thereby opening greater *internal space* within the therapist. Enhancement of *internal space* creates new possibilities for productive therapeutic work. Second, mindfulness redefines the therapist's listening perspectives and redirects his or her attention to inner experiences. This helps the therapist restore the link between the previously dissociated feelings and his or her contributions to enactments, enhancing understanding of the therapeutic process.

It is important to mention that the therapist's ability to recognize, tolerate and effectively integrate his or her emerging thoughts, feelings, fantasies, and actions is facilitated by the cultivation of a self-accepting stance towards oneself and one's experience. As part of the unfolding experience, the feeling of self-judgment itself often becomes the focus of the therapist's awareness. While any therapist will occasionally experience feelings of self-discontent, it is crucial to recognize such emotions rather than vehemently try to alter or circumvent them. For example, while the therapist may be capable of an empathic response towards an aggressive patient in one moment, another moment may lead the therapist to a space in which he or she will not feel empathic. Instead of trying to feel empathy in every instance, the therapist must work toward acceptance of his or her subjective reactions to the patient's expression of aggression as it occurs in the moment. If the therapist is capable of facing the feeling of self-judgment, its effect will weaken. This, in turn, will lead to a certain type of surrender, a type of "letting go" on part of the therapist. The need to dissociate experiences will no longer define the therapist's reactions, replacing maladaptive, constrictive internal experiences with a sense of growing internal space. This is the space which can now, through self-acceptance and surrender, hold the possibilities for fuller acceptance of the other and, through this, of constructive therapeutic work (Safran, 2003, 2006; Safran & Muran, 2000). Therefore it is essen-

tial that therapists can recognize, regulate and constructively utilize their own affective responses in treatment if they are to help their patients to gain this capacity.

Let us now consider the mechanism through which practice of mindfulness can facilitate better affect regulation in the patient. Since both the therapist and the patient are entangled in an enactment, disembedding can only ensue as a result of a jointly achieved understanding of each participant's role in it. Such an understanding represents a new possibility of awakening for both the therapist and the patient. Specifically, the extent to which the therapist will be aware of an enactment and will attempt to disembed from it, will determine the patient's ability to engage in a new kind of a relational experience. While underlying relational schemas can be quite resistant to change, these novel relational experiences can begin to modify the patient's initial maladaptive relational schemas over the course of treatment.

METACOMMUNICATION AND USE OF SELF

Continuous collaborative examination and communication about the patterns that unfold in the therapeutic relationship is referred to as *therapeutic metacommunication*. This collaborative process can be conceptualized as a form of dialogical mindfulness practice. Therapeutic metacommunication plays an important role in the process of disembedding from enactments. Metacommunication involves commenting on the enactment that is taking place. For example, while the patient's overt statement to the therapist is: "There is nobody there for me", the implicit communication might be "You're not there for me." Likewise, therapist who says to the patient: "What is happening in our relationship reminds me of what happens in many of your other relationships," may implicitly be saying: "The problem lies with you, not me". Thus, metacommunication involves labeling and making explicit that which is being communicated implicitly. Metacommunication is a type of *mindfulness-in-action* (Safran & Muran, 2000). To arrive at effective metacommunication, it is essential that the therapist be as connected as possible with his/her emerging feelings and grounded to the utmost degree in his/her immediate experience of the therapeutic exchange. Thus, collaborative exploration of each other's relational schemas begins with the therapist's examination of his own feelings and experiences.

Metacommunications can be formulated in a variety of ways. The therapist may, for example, share with the patient the impact the latter might have on him or her by saying: "I feel that I have to be very vigilant with you... almost as if I am walking on eggshells.", or "While we discuss important issues, it remains difficult for me to

really feel you" or "I often feel with you as if I am to blame for your problems." Such expressions of therapist's response invite the patient to explore his or her inner experiences of the relationship in return.

It is important to keep in mind that the therapist's experience of "feeling blamed" might reflect his own relational schema rather than the patient's. Hence, it is imperative to explore the patient's reaction to the therapist's feedback. If this feedback finds any resonance with the patient's experience, this can lead to further exploration of the patient's contribution to the therapist's feelings of being blamed. However, if the therapist's reaction does not make any sense to the patient, it might be the therapist's own schema that is contributing to this feeling rather than anything the patient said or did. Or alternatively, the patient may in fact be blaming the therapist but is unaware of this in the moment. It is important for feedback to be offered to the patient with *skillful tentativeness* and for the *therapist to emphasize his or her own subjectivity*. The communication by the therapist should be probing. Rather than trying to convey an objective tone, therapists should emphasize the exploratory nature of the communications. The therapist does not have a privileged perspective on reality. The message at both overt and implicit levels should invite the patient to participate in an open and mutual exploration of what is taking place in the exchange. By virtue of stressing the subjectivity of his own perceptions, the therapist conveys to the patient that his or her feedback and observations represent a point of departure for self-exploration. If this tentativeness is genuine, it will increase the likelihood that the patient will be able to use this as a stimulus for self-exploration rather than experience it as an assault or act of persecution. Therefore he or she will not feel compelled to respond either positively or negatively to the therapist's observation, but will instead engage in the process of collaborative discovery. This once again points to the mutuality of this process: the therapist must be constantly open to uncovering, owning and tolerating his or her own role in the very aspect of interaction that is being discussed with the patient. Unless this is truly the therapist's approach, no genuine tentativeness of the exploration can be offered to the patient.

Principles of metacommunication

It is important to realize that *a clear understanding of what is happening within an enactment does not necessarily need to precede the process of metacommunication.* Gradually articulating the therapist's and the patient's current perceptions and feelings leads to a more authentic formulation of the enactment, grounded in collaboration with the patient. In this case, it can be helpful if the therapist can point directly to the actions of the patient that elicit a certain reaction in him or her. For

example, the therapist might share with the patient: "I feel dismissed by you right now, and I think that may be because you tend to not pause and reflect on what I just said, which makes me feel that you are not really interested in what I have to say to you." The purpose of such feedback is to increase the patient's awareness of the ongoing interaction as it unfolds in the moment. During this process, collaborative exploration of the therapeutic relationship and disembedding can be taking place simultaneously.

Another important understanding is that *the therapist should not assume a parallel with other relationships*. Although the process of metacommunication helps to serve as means for disembedding from enactments and, over time, modifies maladaptive relational schemas of self-other interactions, therapists should be wary of establishing premature links between the enactments in the therapeutic relationship and other relationships in the patient's life. Although such parallels can be ultimately informative, they can also be experienced by patients as blaming. Thus, the exploration of the patients' internal states should be carried out in a nuanced fashion, as they come forward in the emerging moment.

Further, *formulations should be grounded in awareness of the therapist's own feelings*. The therapist should always begin by attempting to reflect on his or her own evolving emotions. Taking responsibility for one's own contributions to the interaction is critical to successful exploration. Explicitly owning one's contributions to the process can shed light on the mutual relational schemas. Conversely, failure to do so will lead to greater distortions on both conscious and unconscious levels. If successful, the process can help the patient to become aware of unconscious or semiconscious feelings that he or she may have difficulty articulating. For example, the therapist's acknowledgement of having been critical towards the patient can help the latter articulate his/her feelings of hurt and resentment. Further, by validating the patient's perception of the therapist's actions, the therapist will reduce his or her own need for defensiveness.

It is also essential that *the therapist evaluate and explore patients' responses to interventions*. The patient's reaction to interventions must be constantly examined. It is important for the therapist to know if the patient is using the intervention as an incentive for further exploration or if the patient is reacting in a way hindering further understanding. Does the patient respond in a minimal fashion without elaboration? Does the patient not respond at all? Does the patient react in a defensive or self-justifying manner? Does the patient agree too eagerly in what seems to be an attempt to be a "good" patient? The therapist must carefully listen to his/her own subtle intuitions about the nature of the patient's responsiveness, carefully but openly acknowledging his/her impression of the patient's response. As an illustra-

tion, the therapist may sense the patient's ambivalence in response to a certain intervention, even though the patient may have difficulty articulating cues to such a response. If and when an intervention fails to deepen exploration or in fact further inhibits such an exploration, it is vital that the therapist explores the way in which the patient has experienced the intervention. Did the patient experience the therapist's intervention as critical, blaming, or accusatory? Did the patient experience it as domineering, demanding, or manipulative? Over time, this type of collaborative exploration can help both the therapist and the patient to articulate the nature of the enactments that are taking place. In addition, such explorations can foster the patient's awareness of his or her typical ways of perceiving interpersonal communications, gradually leading to understanding and ultimately to the modification of his or her maladaptive relational schemas.

Finally, *the therapist should keep in mind that an attempt to explore what is taking place in the therapeutic relationship can function as a new cycle of an ongoing enactment*. Enactments are not confined to specific episodes, and different types of enactments can be taking place at the same time. Therefore, the therapist might feel that a metacommunication is targeted at disembedding while substituting one type or one aspect of an enactment for another. If this occurs, the unsuccessful metacommunication will not promote disembedding and will in fact complicate the situation by giving the therapist a false sense of making a sincere attempt to disembed. For example, as the therapist shares with the patient a growing sense that the patient is withdrawing, s/he might say "It feels to me like I'm trying to pull teeth." While this metacommunication is an attempt to disembed from an enactment, it is also colored by the therapist's frustration. The patient accurately perceives this frustration, feels criticized and withdraws even further, or, alternatively, out of fear of further criticism, tries very hard to be a better patient from that point onwards. Thus, the existing interpersonal dance continues. It is therefore important to monitor quality of the patients' responsiveness to all interventions, and to explore his or her inner experiences of interventions that have not been helpful.

To illustrate how these principles are applied to practice, we will now offer a brief clinical example. We will demonstrate how, focusing the patient's attention on his/her own affective responses to the process, the therapist attempts to metacommunicate his/her feelings and thoughts to the patient. By accepting his/her own emotional reactions and by sharing them with the patient, the therapist endows the patient with the capacity to do the same, while also enhancing his/her internal resources to tolerate emotional reactions to the patient's difficult affect. As a result, both the patient and the therapist have more internal freedom to accept, regulate, and constructively utilize their affective states within the exchange.

The clinical exchange offered below represents an initial phase of treatment with a desperate and angrily demanding patient, whom we will call Samantha.

A CLINICAL EXAMPLE

Therapist: So this is our third session, and I am wondering if you have any reactions to our last session.

Samantha: To tell you the truth, I'm not very happy. I am not happy at all. In fact, I'm very frustrated with you, if you really like to know. Last time, I came in and just sat here and talked and talked and talked. And you just sat, and nothing came from you. Absolutely nothing. And this is making me angry. What's the point then? If I am going to be coming here, spending my time and energy and spilling my guts, I want something in return. I want some answers. I need to know how to get to a different place in my life. How are you helping me by being quiet all the time, is what I wonder!

Therapist: Ok, so I'm hearing that you're disappointed and frustrated by our last session. I also understand that you wonder whether and how I can help you.

Samantha: You bet! How is this going to work for me? Nothing helped before! So how is this going to be different? How do I get my issues solved?

Therapist: Ok, I'll try to give you some answers, but frankly I am not sure that what I am about to say is actually what you are asking me to provide. I'll do my best though, ok...

Samantha: I'm not sure why you're concerned about whether you are giving me what I want. Isn't that your job? Should not you know exactly how things are supposed to work? I'm completely confused now.

Therapist: Yeah, I mean, you are right, it is my job to try to help you and answer your questions, yeah, but there is something about the way...it's a bit difficult for me to put into words...but something about the intensity with which you are asking for things which... which makes me question my ability to give you the answer that you're asking for. But I'll try...ok? Basically, 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 in which you may see things that are self-defeating or ways in which you are dealing with your feelings that are self-defeating, or ways in which...you're shaking your head?...

Samantha begins the session by expressing her anger and frustration and by pressuring the therapist to provide her with an explanation of why therapy would be helpful or, better yet, with solutions of what is to be done. The therapist metacommunicates his concern that it is going to be difficult to satisfy Samantha, and then begins to carefully explore her reaction to this metacommunication. One should note that this first endeavor of metacommunication has not yet led to a positive shift in the quality of the therapeutic relationship. However, 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, the therapist begins to regulate his own affect and, in doing so, avoids responding defensively.

Samantha: ...Why would I be defeating myself? Why would anyone? It does not make any sense. I just don't see how we'll be working together and how it will help. Why wouldn't you just give me answers? Right? I am confused, so I ask questions and you give me answers. I don't see how talking about this stuff that you mentioned is going to help. Because I don't think I'm defeating myself.
Therapist: Um-hm.
Samantha: I don't think I'm defeating myself at all.
Therapist: Um-hm.
Samantha: Like I said, I need answers and you're not giving them to me.
Therapist: Um-hm. I would be happy to give you answers if I had them. And when I do, I will. But most of them will have to develop from our work together, because we need to be exploring things together.
Samantha: Yeah, well, that's way too abstract for me. Give me something concrete. Right now, I just need to know how to get from point A to point B.
Therapist: Um-hm.
Samantha: And if I'm just gonna sit here and get this abstract stuff...it's kind of wasting my time, isn't it? It's kind of a waste of my time. That's what the past two years have been with other people. I can't afford it. No way. It's just a waste of my time if I just sit and listen in the abstract, right?
Therapist: Um-hm, yeah, you know I'm trying to think if there is any way that I can be more concrete than I am right now. Um, let me...let me give you an example, ok?
Samantha: 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 under-

stand 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 – 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...

Samantha: Isn't it your job? To produce something...to give me an answer? Isn't that what you are supposed to be doing?

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.

Samantha: But you are asking me to perform too! Aren't you asking me to give you stuff too?

Therapist: Can you say more about that. Does it seem...?

Samantha: Well, you are asking me to give you what's going on with me, aren't you? So I'm being asked to produce something too? Aren't I?

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

Samantha: You bet I did. I felt like you're blaming me. I came in and 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?

Samantha: 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?

Samantha: Ok, yeah, ok.

Therapist: Ok.

The therapist clearly suspects that any attempt to provide an answer to Samantha's question will probably fail. On the other hand, the therapist also realizes that not to

do so will be experienced as hostile and dismissive and will exacerbate the patient's discontent. Therefore, the therapist provides a short formulation. As Samantha does not find the answer helpful, she continues to express her anger and frustration further. The therapist then puts into words the way in which the pressure felt from her makes it difficult for him/her to offer an answer that will feel helpful to her. By formulating his/her emotional response to the patient's behavior, the therapist starts the process of metacommunication. As the therapist shares with Samantha aspects of the process, which appear to him/her problematic or conflictual, his/her internal space needed to see the clinical situation with greater clarity is enhanced. While the initial metacommunication is not immediately helpful to Samantha, it continues to help the therapist be mindful of his/her own response and to regulate his/her own affect. The therapist's own successful affect regulation reduces the possibility of exacerbating Samantha's affective disregulation through the therapist's own disregulated affect. Further, when Samantha shares that she feels pressured to perform as well, the therapist queries if she has experienced his/her metacommunication as an accusation. As noted earlier, monitoring and exploring the patient's experience of the therapist's intervention is a vital principle of metacommunication. In response to this probe, Samantha is able to acknowledge her feeling of being blamed. Thus, the joint exploration of their mutual contributions to this exchange and the feelings evoked by them leads to the softening of the enactment, and disembedding is initiated. The therapist articulates what his motivations are and is able to acknowledge that perhaps s/he has been responding defensively to a feeling of being attacked. The therapist frames their exchanges in terms of the vicious cycle that they are both caught in: "You're saying, I am not doing my job, and I'm saying you're not doing your job." At this point Samantha begins to soften. Therapist and patient are beginning to shift to a more positive cycle of mutual affective regulation. The beginning of an alliance is established around the goal of collaborating to find their way out of this enactment.

The above example demonstrates that, as the therapist turns to the skills of mindfulness, s/he gains awareness of his/her own emergent emotions in the session, which s/he then attempts to metacommunicate to the patient. By doing this, the therapist engages the patient in a mutual exploration of their emotional responses to the ongoing exchange. Discussing openly their internal experiences during the interaction helps both the therapist and the patient to understand and own their respective contributions to the enactment. This newly gained knowledge of his or her affective response and the impact it might have on the other party endows both the therapist and the patient with a greater freedom to utilize their emotional reactions in a more advantageous fashion. In addition, as the patient discovers through

this exploration that she might be evoking difficult feelings in the therapist, and observes that the therapist is nevertheless capable of integrating and regulating these challenging feelings, she learns to accept and better regulate these emotions herself. As both the therapist and the patient become less attached to their defensive responses and their affective reactions become better regulated, further exchange is less defined by their habitual unproductive patterns of responding, and disengagement from the enactment ensues.

CONCLUSION

Many forms of psychopathology are associated with deficits in the individual's ability to integrate and constructively utilize various affective states. One's affective reactions as well as the impact he or she might be having on others when motivated by these reactions often take place outside of one's awareness. An ongoing exploration of one's perceptions, feelings, and motivations contributing to undesirable emotional and behavioral responses leads to enhanced awareness of his or her maladaptive ways of interpersonal functioning. If one possesses a better understanding of motivations behind his or her own actions, one will be more flexible in owning, regulating and utilizing a gamut of affective states. As a result of better affect regulation, the individual will be less likely to act impulsively and to utilize his or her routine maladaptive patterns of behavior.

One way to move toward greater awareness of the patient's distinctive patterns of interpersonal functioning is to examine his or her emotional and behavioral responses to the interactions with the therapist, as they emerge in treatment. If left unexamined, undesirable interchanges, which are co-created in the therapeutic situation, can become an impediment on the road to therapeutic change, leaving the patient's maladaptive relational schemas intact and promoting disregulation of affect. Conversely, when difficult interactions are openly explored, therapists and patients become aware of the relational patterns that are problematic for them in the clinical situation as well as outside of it.

To engage in this joint exploration, the therapist will need to skillfully regulate his or her own affect so that he or she can tolerate difficult emotions elicited by the patient. The therapist must cultivate ongoing awareness of his/her affective responses to the patient as well as an understanding of his/her own contributions to the difficult exchanges in treatment. The practice of mindfulness, which helps the therapist to remain grounded in the moment and to focus attention on his/her emergent affective experiences, can pave the therapist's way into heightened levels of aware-

ness. Successful metacommunication can be viewed as mindfulness-in-action, and is instrumental in helping the therapist to convey to the patient his or her emergent thoughts, feelings and dilemmas about the process in a tentative, exploratory fashion. Recognizing and owning his or her own contributions to difficult interactions requires that the therapist be capable of self- acceptance.

If the therapist possesses the ability to tolerate his or her own painful affect as well as the patient's, and is capable of self-acceptance, the patient will learn that difficult feelings can be tolerated within the relationship. The patient will then be able to accept such feelings in him/herself without dissociating them, and will ultimately develop the capacity for effective self-regulation in a variety of interpersonal contexts, similar to or different from those co-created with the therapist. Enhanced awareness of one's affective reactions and of the impact he or she might have on others, bestows the patient with greater freedom in choosing his or her emotional and behavioral responses in interactions with others, leading to more rewarding, healthier functioning.

REFERENCES

Aron, L. (1996). *A meeting of minds: Mutuality in psychoanalysis*. Hillsdale, NJ: Analytic.

Beebe, B., & Lachmann, F. M. (2002). *Infant research and adult treatment.* Hillsdale, NJ: Analytic.

Benjamin, J. (1988). *The bonds of love*. New York: Pantheon.

Bowlby, J. (1988). *A secure base.* New York: Basic Books.

Ekman, P., & Davidson, R. J. (1994). *The nature of emotions: Fundamental questions*. New York: Oxford University Press.

Frijda, N. H. (1986). *The emotions*. New York: Cambridge University Press.

Greenberg, L. S., & Safran, J. D. (1987). *Emotion and psychotherapy*. New York: Guilford.

Jacobs, T. (1991). *The use of the self: Countertransference and communication in the analytic setting*. Madison, CT: International Universities Press.

Jones, J. M. (1995). *Affects as process: An inquiry into the centrality of affect in psychological life.* Hillsdale, NJ: Analytic.

Leventhal, H. (1984). A perceptual-motor theory of emotion. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (pp. 117-182). New York: Academic.

Lichtenberg, J. (1989). *Psychoanalysis and motivation*. Hillsdale, NJ: Analytic.

Mitchell, S. A. (1988). *Relational concepts in psychoanalysis*. Cambridge, MA: Harvard University Press.

Mitchell, S. (2000). *Relationality: From attachment to intersubjectivity*. Hillsdale, NJ: Analytic.

Parkinson, B. (1995). *Ideas and realities of emotion*. London: Routledge.

Safran, J. D. (2003). Psychoanalysis and Buddhism as cultural institutions. In J. D. Safran

(Ed.), *Psychoanalysis and Buddhism: An unfolding dialogue* (pp. 1-34). Boston, MA: Wisdom.

Safran, J. D. (2006). Before the ass has gone the horse has already arrived. *Contemporary Psychoanalysis, 42,* 197-212.

Safran, J. D., & Greenberg, L. S. (1991). *Emotion, psychotherapy, and change.* New York: Guilford.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide.* New York: Guilford.

Schore, A. N. (2003). *Affect dysregulation and disorders of the self.* New York: Norton.

Spezzano, C. (1993). *Affect in psychoanalysis.* Hillsdale, NJ: Analytic.

Tronick, E. (1989). Emotion and emotional communications in infants. *American Psychologist, 44,* 112-119.