**INHABITING AFFECTIVITY: CULTIVATING AFFECT TOLERANCE IN PSYCHOANALYTIC TREATMENT**

**Michael Pariser, Psy.D.**

“It is not within the capacity of psycho-analysis entirely to spare the patient pain; indeed, one of the chief gains from psycho-analysis is the capacity to bear pain.” Sandor Ferenczi, 1928

**Introduction**

It is, by now, a commonplace observation that a person’s experience of affect forms the center of the psychotherapeutic enterprise. But why affect? What feature of the experience of affective life is so critical to the process of change? To me, the answer is clear: affect tolerance: a person’s ability to consciously and non-defensively inhabit an alive and embodied emotional world. This is not to say that all analytic action can, or should be, reduced to this one notion; in fact, close attention to the patient's affective experience must always be accompanied by careful interpretive work. Nonetheless, I believe that a close examination of most theoretical formulations and all good clinical work will show that the ability of patient and analyst to stand within living emotional experience is a central ingredient in what makes psychoanalysis work.

Fleshing out my definitions a bit, although I use the term “tolerance,” I do not think of it as an individualistic endurance test, but rather as living in an emotionally alive world. It is a fully embodied experience, akin to what Winnicott (1960) described as “indwelling in the psyche-soma”, dependent upon the integration of bodily feelings with the language for those feelings (Socarides and Stolorow, 1985; Krystal, 1988; Stolorow and Atwood, 1992). In addition, affect tolerance is not just an attitude of acceptance toward a specific emotional experience at a given moment in time, but also an overarching sensibility towards feeling life in general, which is that inhabiting the full range of one's feelings, even if painful, is desirably enlivening and, as a goal, is preferable to defensively exiling them from conscious experience.

The question also needs to be addressed as to whose affect tolerance is under discussion. It is tempting to focus on the patient's, in the belief that it is the cause of his problems in living. To a very great extent, however, the analyst's affect tolerance is a necessary precondition for the patient's emotional growth. This is so because any affect states that the analyst cannot consciously experience will be defensively aborted, thus preemptively scuttling such critical therapeutic processes as empathic resonance and self-reflection. Given this understanding, affect tolerance is better conceptualized as a property of the intersubjective system (although at different points in this paper, I will refer more specifically to one party or the other).

**Historical Review**

Historically, affect was often considered problematic, and thus the role of affect tolerance was implied, more than it was explicitly avowed. Nonetheless, an examination of almost any theoretical formulation demonstrates the key role necessarily played by affect tolerance in the mechanism of analytic action. For instance:

* Freud’s (1914) aim was for his patients to renounce their infantile wishes, accept appropriate partners, settle down, and sublimate; but the patient's awareness and exposure of infantile longings, of necessity, evokes feelings of shame and vulnerability, along with the anxiety of retraumatization or the destruction of relational ties. The patient could not move on towards renunciation without tolerating those difficult affects.
* Klein (1935, 1946) proposed that matriculation from the paranoid-schizoid into the depressive position necessarily produces guilt, mourning, and envy, all of which would have to be tolerated by the patient in the process of psychological growth.
* Kohut (1983) envisioned the steady cohering of the patient's self through the emergence of, and adequate environmental response to, selfobject longings and optimal frustration in the transference. The process of cohesion, however, is generally arduous, and often painful feelings emerge - anxiety and disorientation, frustration, confusion, even hurt and anger - that the patient would have to inhabit meaningfully if the process were to lead to growth and change, rather than to impasse and stagnation.

In the contemporary world, where analytic formulations overtly privilege emotional life, the role of affect tolerance is even easier to detect.

* In Mitchell’s relational-conflict model, the analyst’s inevitable fate is to be woven into the fabric of the patient’s relational tapestry. His task was to understand how that came to be, and then, using his new-found understanding, extricate himself and the patient from that conflicted and confining weave.
* Bromberg’s (1998) approach to trauma-based dissociation involves identifying discontinuous self states and then “standing in the spaces” between them.
* Clinical Attachment Theory seeks to transform the patient’s internal working models by reintegrating into the patient’s narrative experiences which have been defensively withheld.

In all of these theories, the treatment process involves the simultaneous presencing of conflictual elements, along with their discrepant affect states. Not only the individual elements, but also the resulting conflict can evoke painful feelings, including the confusion of cognitive dissonance, the anxiety from the need to relate in new and different ways, the fear that a more complex presentation will result in rejection, and the disorientation of an overarching loss of certainty in the world. Progress in resolving these conflicts and moving forward would unavoidably involve the embrace and integration of the many painful affect states inevitably arising in the process.

**Thinking about Feeling**

Considering the central place inhabiting one’s affectivity occupies in our ideas about development and treatment the main question becomes how can we best cultivate our and our patients’ experience of embodied affectivity? What shifts must we make in the way we work so that the experience of affect tolerance can be pursued as a goal in and of itself? Perhaps the most important of these involves a change in the idiom in which feelings are thought about by the clinician: in particular, by the analyst moving as much as possible to a language of direct phenomenological description in his conversation with himself.

Language matters, and the language in which the analyst talks to himself necessarily impacts the intersubjective field, often unconsciously. If, for example, while listening to my angry patient harangue me with a list of my many shortcomings as an analyst, I tell myself that my patient is a "borderline" or “histrionic”, I will speak and act in very different ways than if I do not. For this reason, I try to talk to myself and my patient phenomenologically, which is to say, in as simple, everyday, descriptive language as is possible. I don’t try to translate the experience into a more overarching conception, such as a theoretical construct, unless I really have to[[1]](#footnote-1). Moreover, I don’t shift into explorations of causality, but, in the belief that dwelling in affectivity is itself developmental of psychological growth, I seek to help the patient amplify and live within his emotional experience.

Doing so, I find our emotional interactions generally more vivid and clear, and, as a result, easier for us to track and address. Our enhanced abilities to stay attuned to our ongoing and shifting emotional states lead, in turn, to understandings that are more likely to resonate with both of us and seem less subject to misinterpretation, making it easier, as a rule, to come to agreement about the patient's subjective experience. Interestingly, agreement facilitates disagreement, as any sense the patient has of diverging from my understanding stands out in sharp relief, and thus he is more likely to bring it to my attention. Finally, since emotion is not being intellectualized or abstracted in the process, the use of direct description tends, all by itself, to intensify and embody feeling, which, if fully inhabited, helps generate long term integration, which I believe to be the ultimate key to emotional growth and change.

**Inhabiting Affect**

If speaking and thinking as much as possible in direct experiential language immediately allows for greater access to the patient's emotional states, it also raises the question: how can the analyst understand the emotion that emerges, or fails to? In other words, the patient says, “I feel sad” or doesn’t. Now what? Utilizing an essential concept from Intersubjective Systems Theory (Stolorow et al, 1987), the patient’s state of being with the analyst will foreground either the developmental or the repetitive dimension of the transference.

When in the developmental dimension, the patient experiences the analyst as a potential home for emotional longings that were thwarted in childhood and were thus experienced as dangerous. The analyst’s role, in this case, is to help the patient experience these feelings, amplify them if necessary, integrate their somatic and symbolic (language) components, and ultimately accept them as welcome aspects of an ongoing sense of self.

By contrast, when the repetitive dimension is in the transferential foreground, the analyst will be seen as potentially (or actually) retraumatizing to the patient, who will defensively withhold painful feelings not only from the analyst but possibly from himself as well. Once it becomes clear that affects are being defensively aborted, the analyst’s task is to investigate the dangers that make such defensiveness necessary. This is a critically important aspect of analytic process, and one that may form the bulk of treatment, especially in its early stages.

To do so, I find it helpful to remember that, despite appearances to the contrary, an affect state is not a monolithic mental activation; it includes not only physical and mental sensations, but also a cluster of related elements: feelings about the feelings (second order feelings), historically generated cognitive meanings, interpersonal expectations, and dispositions to action. Additionally, all affect states are intrinsically bound up with, and reflective of, the individual's connection to his lifeworld (Orange, 2010). Therefore, another critical element of any affect state is its given contextuality. Any and all of these factors can form the basis of emotional prohibitions, and it can be extremely helpful for the clinician to identify the most prominent in the aborting of feelings, so as to more narrowly target the danger involved. I break them down into the following four categories.

History and acquired meanings: Over the course of childhood, caregivers’ practices of reward, acceptability, and tolerance, or, alternatively, punishment, neglect, and intolerance, generate cognitive meanings about, and levels of tolerance for, each emotional state, as well as for affective life in general. These meanings become enshrined as organizing principles (Stolorow and Atwood, 1992) that help determine whether a given affect state will be felt to be dangerous and unbearable or safe to be experienced and expressed. Putting these automatic meanings into words helps allow the patient to realize that the emotional world he has long inhabited is being unconsciously structured in ways that limit his freedom and sense of aliveness.

Feelings about feelings: affect states felt to be unacceptable evoke other emotions that serve to warn against awareness or expression, and which therefore pull for defensive countermeasures: repression, dissociation, enactment, etc. Shame and anxiety are the commonest of these second-order feelings, but almost any emotion can be triggered, including terrors of loss of control, overwhelm, disintegration, or other states of personal annihilation that render the original affect unutterably unbearable. In this case, the analyst first needs to help the patient inhabit the second order feelings. When these become more tolerable, the original feelings can more easily be inhabited as well.

Decontextualization (cf. Maduro, 2008) defines a broad category of emotional experience in which affect states are stripped of one or more aspects of their inherent contextuality. They include: (1) the idea that the emotion will last forever (stripped temporality), (2) the sense of the affect as triggered by everyone and everything (stripped individuality), (3) the experience of emotions as belonging only to and only about the individual (stripped relationality) (4) the certainty that an affect represents not a transitory emotional experience but rather an inherent and ineradicable fact about one’s self (stripped immateriality) and (5) the belief that affect states correspond directly to external reality( stripped subjectivity). Feelings are significantly less bearable when they are felt to be permanent and ubiquitous, confirming of inherent defects, or ineradicable facts about one's self than if they are experienced as temporary and connected to a specific emotional context. A process of recontextualization, in which the missing contextual elements are reintegrated, helps lessen the felt sense of danger.

Present relational context: the current situation in which an affect is being activated and experienced. In psychoanalysis, the patient’s ability to integrate painful affect is strongly influenced by the analyst’s ability to help create what Stolorow calls a "relational home", defined as "a context of human understanding", for the patient's often painful subjective experience (personal communication, Los Angeles, 2010). How does a relational home work?

To begin with, the patient's experience of an affectively welcoming environment helps disconfirm his expectation of rejection and generates, by contrast, a sense of connection and acceptance that reduces the intensity of the patient’s attendant anxiety and shame (feelings about the feelings). In addition, although the new feelings may be painful, with the analyst's empathic attunement, the patient can experience himself, perhaps for the first time in his life, as accompanied in his pain. An experience of being not alone can, in turn, allow the patient to remain consciously within the feelings for a longer period of time, enabling an increase in longer term reflection and a reduction of his normally automatic requirements for antidotal actions. Finally, all these factors generate a meaningful process of creative chaos (D.B. Stern, 1997), a de-structuring of basic emotional organization that allows for expanded horizons and greater experiential freedom.

Becoming a relational home, and therefore courageously inhabiting painful affect, is not always embraced by clinicians, who may instead join with patients in the overt goal of eradicating problematic feelings. For example, a patient may report feeling depressed and demand of the therapist, "How are you going to get rid of this?" Many therapists, eager to alleviate the patient's suffering or afraid of losing the patient, will agree to try to do precisely that: rid the patient of his offending affect states by any means possible: interpretation, suggestion, reassurance, and, of course, medication. Such an approach, however, will generally backfire in the long run, as affects not integrated will, once again, need to be defensively aborted.

By contrast, an affectively oriented approach emphasizes the radical acceptance of all affect states, seeing every one as embedding important information about the patient’s relation to himself and the world around him. Thus, he will try to inhabit, and help his patient inhabit, not only commonly occurring feelings of hurt, guilt, fear, and sadness need to be accepted, but also more extreme and difficult states: bitterness, burning shame, murderous rage, abject futility, and utter despair. This is true as well for feelings about feelings. A patient may report hating himself for feeling a certain way – ashamed, say – and not only the shame will need to be inhabited, but also the self-hatred as well by both clinician and patient.

Because humans in interaction form intersubjective systems (Coburn, 2002; Beebe and Lachmann, 2002; Seligman, 2005) the four elements combine in complex ways, activating and reinforcing each other. For instance, it is likely that the harsher and more consistent the history, the more rigid or punishing will be the acquired meanings, and the greater will be the tendency to decontextualize. The result may be affect states deemed to be inherent, permanent, and unchangeable, such that when they arise, they are more likely to evoke painful feelings about the feelings. The greater the intensity of these second-order affects, the more difficult it will be to interact constructively with others, so that there is apt to be a decreased chance of finding a relational home for the original, painful feelings. And finally, the less secure a relational home, the greater will likely be the call into action of defensive regulatory capacities such as dissociation or enactment. Often, it is only in the clinical setting that this cascade of emotional cause-and-effect can be effectively examined and unlinked.

As stated above, what is true for the patient with regard to inhabiting affect is also true for the analyst. It is difficult, if not impossible, for an analyst to help a patient integrate affect states that the analyst himself is afraid to embrace. Moreover, impasses and enactments, along with intersubjective conjunctions and disjunctions, generally arise out of areas of mutual defensiveness (Elkind, 1992), domains of affect that both patient and analyst cannot bear. Arguably, such phenomena constitute a shared, non-verbal avenue by which the dyad struggles with the reciprocal intolerability of feeling. A number of Relational theorists (e.g. T. Jacobs, 1986, 2001; Davies, 2003; Bass, 2003;) have shown, when in the grip of an enactment, that self-reflection, leading to emotional awareness and, often, honest self-disclosure, can provide the traction necessary to break the analytic logjam. In other words, since the system’s inability to tolerate affects makes the defensive operations necessary, an analyst’s ability to move into previously disowned feelings can be pivotal in advancing a stalled treatment.

**Case Example: Brandt**

The following case illustrates the critical importance of tolerating and embracing painful emotions, along with the danger of failing to fully do so. In addition, it reveals the impact of the four individual factors at different points in the treatment.

When I first met Brandt, I immediately got the impression of strength. Nonetheless, he told me that his chief goal in psychotherapy was to get “stronger”. I soon discovered that he meant I was to help him get rid of various emotions he identified with weakness, emotions such as fear, depression, and despair. Brandt, in his mid 60’s, has long experienced his body as a kind of emotional fortress that protects him from emotional attacks that began in childhood, when he was severely beaten by his mother. When he was about 35, however, an operation left him temporarily unable to exercise, and he experienced the walls of his fortress collapsing. Beset by the terrors he had long been trying to avoid, he succumbed to depression and committed himself to a mental institution, where he spent the next four years.

Once out of the institution, Brandt withdrew. He stopped working and began spending most of his time going to doctors and worrying about his health. He married one of the nurses from the psychiatric ward, who formed the center of his medical “team,”. He has had innumerable tests and surgeries, and he takes a daunting assortment of medications. In fact, his entire way of being resembles a living hospital. As an important part of his overall medical program, Brandt has been in some kind of psychotherapy for 40 years, generally without much alteration in his way of being.

Working with Brandt to help him experience and identify his sequestered affect states, I immediately noticed a change: he became terrified. As he connected to painful emotions, he would look stricken and moan, “I don’t feel good!” As if sitting in an airplane that hit a pocket of turbulence and dropped suddenly, his body would jerk and his hands would thrust outwards, reaching for something to grasp. In his most severe states, he called out pleadingly for his mother.

My response to Brandt’s emotional distress has been to try to sit with him in whatever he experiences. My ability to tolerate his affect, however, is occasionally tested, as when he rages at me for not preventing him from any experience of unbearable pain. Nonetheless, Brandt has made progress. He has begun to identify me as a kind of athletic coach with whom he is in emotional “training”. He is aware that, as a result of our work, he is growing stronger, but in a different way than he had at first anticipated. Rather than by becoming invulnerable to his weaknesses and limitations, Brandt is slowly coming to understand strength as an increased capacity to inhabit his vulnerable and flawed humanity. Despite this palpable progress, however, we still struggle together, as a recent enactment shows.

Brandt hurt his back, and it had caused him severe pain. Over time, however, it seemed to be improving, and with the aid of a brace, he was moving reasonably well. Then one day, at the beginning of a session, he asked, in a demanding tone, if I would be willing to give him my chair if he found it more comfortable for his back. This took me aback, so to speak, and I felt my whole body stiffen. I tried my best to think about what was happening between us, but I didn’t achieve much clarity. On the one hand, I recognized that Brandt might very well be more comfortable in my chair. On the other hand, I was comfortable in my chair, and I didn’t *want* to move. Besides, why now, when he was obviously on the mend? What else might be behind the request? So I suggested to Brandt that we needed to explore his feelings. This infuriated him, and he declared that he now realized that beneath my empathic façade, I was really - in his words - “an uncaring prick”. Plus, now that he could clearly see my deep and unanalyzed insecurities – I obviously needed my big, comfortable chair to feel superior to him – I could be of no further use to him as a therapist.

After the session, I reflected on what had happened. I *had* been resistant to his request, and overtly so. What I didn’t understand was the intensity of my bodily reaction and the intractability of my position. Then I factored in my own physical state, and things began to make better sense. I normally drink a lot of very strong coffee. However, I had that morning quit cold turkey, and I was experiencing a powerful migraine headache, accompanied by sluggishness and slowness of thought. In other words, I felt like crap. I hadn’t wanted to give up my chair because to do so would have meant moving, which was painful, as well as revealing my own physical weakness, about which I was feeling none too proud. So the affect states that were lurking in my background, but which I was not tolerating well, included weakness and vulnerability, along with shame about my weakness, exactly the feelings with which Brandt was struggling.

Additionally, the interaction had resonated with me historically. In Brandt’s demanding tone I heard the voice of my autocratic mother ordering me to submit to her imperious will; and the specter had arisen in my mind of a never-ending enslavement to the tyranny of Brandt’s hypochondriacal requirements. What else might be demanded of me? There might not be any limit to what I would be forced to provide. This was a terrifying feeling for me, and one I hadn’t been able to tolerate during the session, because of its acquired meaning of enslavement, along with feelings of powerlessness and resentment it had secondarily activated. Instead, I had stiffened automatically into a rebellious stance: one based in a pathologically accommodative oppositionality (Brandchaft, 2008), and one from which I had not been able to extricate myself at the time.

The next day, I disclosed my feelings to Brandt. I admitted to my physical condition, and I also shared a bit of my history. In addition, I confessed my inability to put my feelings into words for him, in part because of the limitations of my sluggish thought process. Brandt told me he was touched. He said he realized he had been demanding, and he claimed he wished he had been able to find a more diplomatic way of asking for what he wanted from me. That led to an exploration of his inability to tolerate certain feelings of his own, including envy of what he had seen as my physical strength, concurrently with anxiety about the condition of his own body. He had not been able to bear these feelings, because he believed they would reveal shameful and inherent (decontextualized) defectiveness. Additionally, Brandt disclosed he’d had a fear that I might say no to him and thereby humiliate him in his vulnerable longing for my loving care. This last terror was what had necessitated his aggressive stance. Constructive exploration proceeded from this interaction, centered particularly on Brandt’s struggle to accept *my* limitations, and, by extension, his own. This effort is beginning to allow him to experience and reintegrate sequestered affect states formerly too shameful for him to own.

**Discussion**

This case illustrates the operation of the different elements of a directly affective process. To begin with, the patient presented in the repetitive dimension of the transference, as his request, couched in a demanding tone, embedded the expectation that I would not provide the care he needed unless he forced me to do so. This fear, along with his anxiety that I was planning to reject him for being too much of a burden, reflected automatic meanings generated in a childhood of abuse and neglect. My historic meanings, of course, arose along with his, as did our respective prohibitions against inhabiting unbearable feelings: for him, a vulnerable need for loving care, and for me, the struggle for self-care. Other aspects of intolerability also came into play: decontextualization, for instance, in which he was the ever-present burden and I the eternal slave.

The affective traction that allowed for movement was provided by a process of self-reflection, made possible by the awareness and acceptance of the anxiety I had been feeling. In other words, I was able to integrate the feelings about the feelings, at which point, I could think about the original feelings. Then, integrating what I could not the day before, I was able to attune more closely to Brandt's emotional states and to sort out some of the ways in which our respective needs for protection had interacted to create our impasse.

The following day, in my affective self-disclosure and the ensuing discussing of both my feelings and his, I was able to become a relational home for Brandt’s forbidden feelings, disconfirming, in the process, his expectations of neglect and rejection. Further, he reported feeling less alone and more welcomed, even with his formerly unwelcome affect states. As a result, he lost his sense of urgency to leave treatment and instead began a productive examination of the problematic ways he approaches others when in emotional need.

**Conclusion**

Affect tolerance, as a person’s experience of inhabiting an alive emotional world, is a key element in therapeutic action. Although it is often addressed via metaphoric and abstract concepts, with a clear focus on direct experience, affect states and affect tolerance can be isolated, investigated, and ameliorated on their own. Over time, through assiduous attention to the relational process, both patient and analyst can come to embrace a greater range of emotional states, and, in this affect-rich experiential mode, real analytic progress can be made.

The working through of the impasse with Brandt illustrates this principle clearly. Although our combined *in*abilities to tolerate our respective affect states created an uncomfortable stalemate, our successful struggle to tolerate and reflect on painful emotions released us both from the grip of the enactment and allowed for renewed analytic growth. Although it is a tiny event in a long analysis, it demonstrates a stable, generalizable principle: that once patients become more capable of fully inhabiting their emotional worlds, their lives become freer, richer, and more expansive. Clearly, once affects emerge, are embraced and integrated, they catalyze a broad spectrum of vital possibilities. In the words of Lynne Jacobs (personal communication, 2010), “When you’re not afraid of feelings, then you’re not afraid of life.”

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1. Metaphor and abstraction are not fully avoidable, of course, but all metaphors are not created equal. Many are experience-distant reifications, like “ego” or “internal object” or “bipolar self”. My personal preferences is for those metaphors that either reflect or point to the moment-by-moment processing of intersubjective experience. These include Winnicott's notion of emotional holding (Winnicott, 1960, 1963), the Relational conceptualization of enactments (Bass, 2003; Jacobs, 1986, 2001, etc.) and the idea of a relational home (Stolorow, 2007). [↑](#footnote-ref-1)