CHAPTER 8

THREE PRINCIPLES OF SALIENCE IN THE ORGANIZATION OF THE PATIENT–ANALYST INTERACTION

The Case of Clara

An empirical microanalysis of mother–infant interaction can deepen our understanding of the analyst–patient interaction. In the last chapter, we offered three organizing principles derived from infant research to describe how interactions are regulated, represented, and begin to be internalized in the first year of life. These principles are ongoing regulations, disruption and repair of ongoing regulations, and heightened affective moments. They further define the nature of self- and interactive regulation. They constitute hypotheses about how social interactions become patterned and salient in the first year. We now propose that these principles are applicable to the patterning of analyst–patient interactions and can specify modes of therapeutic action in adult treatment.

Although infant research has been construed as relevant to adult treatment in many ways (see, e.g., Horner, 1985; Stern, 1985, 1995; Sander, 1985; Emde, 1988; Osofsky, 1992; Soref, 1992; Seligman, 1994), in this chapter we explore the proposition that infant research is applicable to adult treatment through organizing principles of
interaction. We view the dyad as a system within which self- and interactive regulation are integrated. The three salient principles of interactive regulation provide further specificity for conceptualizing how dyadic regulations may work and how internalizations may be co-constructed in adult treatment. These principles are relevant both to verbal and to nonverbal modes of regulation.

In reviewing the infant research literature in the last chapter, we conceptualized the three principles of salience in an attempt to organize different ways of viewing dyadic regulation. The three principles do not address the content of such clinical issues as oneness and separation or such motivational issues as needs or wishes. Rather, they address the process and patterning of interactions.

The model of development derived from infant research cannot, of course, be directly translated into the adult psychoanalytic situation. In adults, the capacity for symbolization, and the subjective or unconscious elaboration of experience in the form of fantasies, wishes, and defenses, further modify the organization and representation of interaction patterns. What makes this model appealing for adult treatment, however, is that it makes no assumptions about the dynamic content of adult experience. It focuses entirely on the process of interactive regulation. Thus, despite the many differences between mother–infant and patient–analyst interaction, we propose similarities with respect to how these three principles function to organize interactions. The three principles operate together and can be considered different angles of the camera in a foreground–background relationship.

The three principles are relevant to all sources of therapeutic action. Numerous well-established psychoanalytic concepts already cover the same terrain as do the three principles. Our integration is designed not to supplant these dynamic formulations but to provide analysts a differentiated view of the regulation of interactions and the organization of experience that goes beyond interpretation.

The Three Principles and the Analyst–Patient Interaction

Psychoanalysts have always paid attention to the issues covered by our three principles, albeit those issues have been known under other
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understand the role of dyadic regulation. The three elements of such clinical issues as one-

Theorized interactions.

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of adult experience. It focuses on the process of regulation. Thus, despite the

infant and patient—analyst interaction, the observer and the patient—the three principles operate

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Analyst—Patient Interaction

tention to the issues covered by the analysts have been known under other

names. Ongoing regulations have been subsumed under discussions of patterns of transference and countertransference, the “holding

environment” (Winnicott, 1965), and the “background of safety” (Sandler, 1987). Disruptions and their repair have been proposed as

a basis for structure formation (Stechler and Kaplan, 1980; Kohut, 1984; Horner, 1985) and implicated in the analysis of resistance and

the use of confrontation (Buie and Adler, 1973; Lachmann, 1990). Heightened affective moments (Strachey, 1934; Fenichel, 1938–1939; Pine, 1981, 1986) have been recognized as essential to making analysis emotionally meaningful.

Ongoing Regulations

The principle of ongoing regulations captures the characteristic, expectable pattern of repeated interactions in the treatment situation. Both partners actively contribute to the regulation of the exchange, moment by moment. The analyst has the greater range of flexibility in this process, but the actions of both partners are intimately linked in time, space, affect, and arousal. Expectations are organized that each partner either can, or cannot, affect and be affected by the other in specific ways. These expectations determine the nature of interactive efficacy. Both partners come to expect and represent these ongoing characteristic regulations and their unique interactive efficacy with this partner.

In the treatment situation, ongoing regulations range from subtle nonverbal behaviors, such as postural and facial interactions, intonations and tone of voice, greeting and parting rituals, to verbal exchanges. Ongoing regulations include interactions where the patient narrates and discloses while the analyst attends, reflects, describes, and questions. The effects of such interactions are present throughout the treatment process. However, they can be most clearly illustrated in the phase of understanding (Kohut, 1984) and the processes of listening (Schwaber, 1981), exploring, and clarifying (Greenenson, 1967). These patient–analyst interactions have generally been viewed as a preparatory phase. They have not been recognized as contributing directly to the formation of representations and internalization.
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In these phases, repetitive themes of the patient, for example, expectations of nonresponse, indifference, or rejection, are engaged, potentially disconfirmed, and woven into the patient–analyst relationship. Through this process, these themes are altered, that is provided, as a matter of course, with a new context (Loewald, 1980; Modell, 1984). Thus, we propose that ongoing regulations can promote new expectations and constitute a mode of therapeutic action. Whereas the engagement and disconfirmation of expectations have been described as the interpretive work of analysis (Weiss and Sampson, 1986), they are also characteristic of ongoing regulations. That is, ongoing interactions that are never verbally explored or addressed can nevertheless potentially alter the patient’s expectations.

The detailed study of ongoing regulations can further illuminate the processes of therapeutic action. The structure of the dialogue itself, irrespective of its verbal content, is the subject of study. Patient and analyst construct characteristic ways of asking each other questions, wondering aloud together, taking turns in the dialogue, and knowing when to pause and for how long. In this process both are constructing expectations and disconfirming fears of being ignored, steamrollered, intruded on, misunderstood, or criticized. These inter-actively organized expectations and disconfirmations are represented and internalized, whether or not they are ever verbalized. This process constitutes the therapeutic action of ongoing regulations.

Disruption and Repair

The disruption and repair of interactions is a specific extension of the principle of ongoing regulations. However, rather than emphasizing what is expectable in the interaction, disruption and repair organizes violations of expectancies and the ensuing efforts to resolve these breaches (Steiner and Kaplan, 1980; Horner, 1983; Tronick and Cohn, 1989; Beebe and Lachmann, 1994). Our review of infant research noted the wide range of disturbances encompassed by the term disruption. The continuum extends from the mild disjunctions, rapidly righted, that are typical of successful interactions, to severe ruptures. Although these mild disjunctions can be considered normative, more so during phases of development (Tronick, 1967). Disruptions are very different from the more specific transference of the nature of ‘

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mative, more severe and frequent disruptions may prejudice develop- ment (Tronick, 1989).

Interactions of disruption and repair are most clearly evident during phases of explanation (Kohut, 1984) and during the processes of confrontation, working through, and interpretation (Greenson, 1967). Depending upon how, when, and where they occur, disruptions are variously understood. They may be seen as necessary for development, as emanating from the patient’s resistance, or as due to the patient’s inability to tolerate frustration. Others have ascribed disruptions to poor timing by the analyst, misunderstandings, specific transference–countertransference configurations, or the differently organized subjectivities of analyst and patient. Different notions of “repair” are associated with each of these views of “ruptu” (Kohut, 1984; Blatt and Behr-nds, 1987; Stolorow et al., 1987).

The disruption and repair model lies at the heart of formulations of structure formation and therapeutic action in psychoanaly- sis. Structuralization has been variously assumed to result from the internalization of the lost object, frustration of drive derivatives, or optimal frustration whereby functions of the relationship that were disrupted are constructed within the psyche of the analysand (Freud, 1917; Tolpin, 1971; Klein, 1976; Loewald, 1980; Kohut, 1984; Blatt and Behrends, 1987).

We consider disruption and repair to be only one avenue of structuralization and therapeutic action and as operating during all phases of the treatment. Furthermore, it is an activity of the patient–analyst interaction. Disruptions are neither solely a consequence of the analyst’s countertransference nor a result of the patient’s “resistance.” Repairs are also jointly constructed. The therapeutic action of disrup- tion and repair lies in the organization of a flexibility in negotiat- ing a range of coordination and miscoordination in the process of interactive and self-regulation (Beebe and Lachmann, 1994).

**Heightened Affective Moments**

The term heightened affective moments was originally defined by Pine (1981). In our elaboration, this principle refers to interactions
that are organized when a person experiences a powerful state transformation, either positive or negative (Lachmann and Beebe, 1993; Beebe and Lachmann, 1994). State is used broadly to refer to arousal and activity level, facial and vocal affect, and cognition. Heightened affective moments in the patient–analyst interaction can provide opportunities for new experiences, refining old loves, or, potentially, retraumatization (Lachmann and Beebe, 1992, 1993, 1997). In the treatment of adults, we define affect broadly to include cognition and symbolic elaborations.

For an adult, the heightened moment may or may not include obvious nonverbal features and will include a symbolic context. For example, in the treatment (by Beatrice Beebe) of a highly intellectualized man who was dependent on a continuous verbal flow, a long, shared silence became a heightened moment. At this point in the interaction, the verbal content ushered in a new intimacy, which was then marked by a pause, which was much longer than usual. Both the patient and I extended the pause to savor this new experience. For this patient, the long moment of pausing was felt to be his first “direct” emotional communication to me, without words. It came to symbolize the possibility of a new kind of shared intimacy. This heightened affective moment ushered in a gradual transformation of his self-regulatory style. After this event, the patient had more access to a calmer state, where his verbal flow contained more pauses. There was more room for both my patient and me to reflect, absorb, and experience. In turn, the interactive regulation was altered. I was more present both for my patient and for myself. Both my patient and I increasingly came to be able to describe this altered interactive process in words.

In other treatments, moments of humor (Lachmann and Lichtenberg, 1992) and surprise (Reik, 1935; Lachmann and Beebe, 1993; Wolf, 1993) may organize heightened affects for both analyst and patient. For example, a patient (treated by Frank Lachmann) had been describing her slavish, obsessional attachment to a former boyfriend. He was a sadistic, exploitative man whom she had not seen in over a year. In the last minute of a session, she turned to me in desperation and pleaded, “I am like a deer, caught in the headlights of a car, as her hand opened itself as a deer, a without a drive each other. In mood change a suit of armor, w description of h

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headlights of an oncoming car, unable to move. You have to help me get out of this state. Tell me something to help me!" Stymied, as her hand opened the door to leave, I said, "If you think of yourself as a deer, and you think of him as a car, think of him as a car without a driver." She turned, and for a split second we looked at each other. In the following session, she described her dramatic mood change after the comment. She said, "I thought of him as a suit of armor, without a knight." The patient had elaborated on my description of her image. Her state of helpless desperation was temporarily transformed.

This interaction became a heightened moment for the patient because she felt that I had joined her in sharing her imagery and rescuing her. Although I was stymied at first, it became a heightened moment for me because I succeeded in coming up with an elaboration of the patient's image just in the nick of time and was able to join her in a moment of shared relief from tension. This shared moment marked the beginning of a decrease in her rage at her ex-boyfriend and in her expectation that he rescue her.

Both vignettes illustrate key features of heightened affective moments. The moment is jointly constructed by both participants. An expectation of how the interaction will go is transformed for both analyst and patient. Simultaneously, the patient's state is dramatically transformed. These moments can be integrative, altering the transference. The therapeutic action of heightened affective moments is mediated through state transformations that potentially usher in opportunities for an expanded self-regulatory range and altered patterns of interactive regulation, thus new internalizations and therapeutic change.

In summary, new themes may be organized through all three principles of salience. All three principles alter the context of rigid themes and promote the development of new interactive expectations and thus new internalizations and therapeutic change. In the following case we examine the process of treatment in terms of these three principles to specify in greater detail the sources of therapeutic action. Rather than examining the three principles one-by-one, we weave them into the case.
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Case Illustration

A 36-year-old divorced professional woman, who was seen on a three-session-per-week basis, began her fourth attempt at psychoanalytic therapy with me (Frank Lachmann) with a generally pessimistic feeling. Several years of previous treatments had not succeeded in diminishing her depressive outlook on life, her inability to enjoy herself in any endeavor, or her sense that nothing she was involved in was worthwhile. After the first month of treatment, Clara began her analytic hours with such questions as, How are you going to help me? How is this going to be any different? What good is this going to do?

The way this patient initially organized her experience in treatment was based on her long-standing and pervasive pessimism: nothing would make any difference. When this attitude was reflected to her, she responded that in her previous treatments she had been called “resistive.” She was waiting to see when this label would be applied to her. Furthermore, she anticipated being accused of “masochism,” of being “unwilling to help herself,” and of being “unwilling to make use of the treatment situation.” She expected to be blamed for not improving. In fact, she said that, if she were not blamed, it would only be because I was too nice, in fact pathologically nice, and had a problem with aggression. In that case I would also be unable to help her, and she might as well leave.

Cautious Hope and the Acceptance of Opposition

The patient recognized the importance to her of this grim belief (Weiss and Sampson, 1986) that she would not be helped and that she could not change. I had to monitor myself carefully—and not always successfully—so as not to impose on her a need to make herself an “easier” patient. After several months of exploration, a model scene was formulated based on a childhood experience (Lachmann and Lichtenberg, 1992).

The patient and her family lived on a farm in the Midwest. When she was eight years old she was given a horse as a present. Although she was told how to take care of it, she neglected to fol-
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gress. In that case I would might as well leave.

The patient’s depressive, pessimistic states, her inflexibility, her “resistive” stance in the analysis, and the themes that organized her model scene were explored and formulated as follows: “I must beware of people trying to make me feel good. If I permit them to do so, I run the risk of masking a painful but real event. A feeling of well-being could turn out to be self-deceptive. When others want me to feel good, or want to spare me pain, guilt, or anxiety, it is only out of their own self-interest. My self-respect and integrity demand that I not permit anyone to help me feel better. So long as I feel depressed, guilty and despairing, I know I have maintained my integrity.” In fact, it became critical to the patient that she never acknowledge that anyone could help her feel better. Only by feeling bad could she remain true to her horse. This picture defined the nature of her self-regulation as she entered the treatment.

The joint construction of the model scene and its interpretation became a heightened moment for me. All of a sudden I understood the nature of her battle with me and the dire necessity for her
oppositionalism. However, she was not particularly impressed. She was mistrustful of the "Pollyanish" formulations. In this instance she did not share my heightened affective moment.

Acceptance of the patient's "resistive" stance as plausible and necessary did not yet alter her dread of reexperiencing her self-betrayal. It did, however, provide her with some sense of efficacy, since she had had an impact on me. It also organized an expectation of new possibilities with me as her new analyst despite her worry that I might be too nice. I noted a shift in her depressive state. She became cautiously hopeful in the face of this novel experience of acceptance. In addition, not expecting acquiescence minimized the likelihood of repeating her traumatic childhood experience in the treatment. Nevertheless, we continued to run into numerous severe but temporary impediments. Acceptance of her need to feel hopeless prevented the impediments from turning into impasses.

At this point in the treatment, the patient continued to feel endangered if she did not resist. If she were to reveal her longings to be understood and cared for, she might forfeit her integrity. Although the dread of self-betrayal persisted, we continued to investigate this theme. My acceptance of her "resistance" contributed to reorganizing and disconfirming her expectation that affirmation of my good work would be demanded.

This opening phase of the treatment illustrates the joint construction of a primary mode of ongoing regulation, her cautious hope and "the acceptance of opposition." My acceptance of the necessity of the patient's opposition and distrust and the patient's cautiously hopeful response became a new mode of interactive regulation.

This ongoing regulation can be evaluated in relation to the therapeutic dilemma that constrained the treatment. The dilemma was that the critical, contemptuous, confrontational, pessimistic stance of the patient, interwoven with hints of suicide, carried a continual possibility of my reacting with impatience, irritability, withdrawal, and blame. New modes of interactive regulation were required that nevertheless accommodated the limitations in the self-regulatory range of both the patient and me. On the patient's side, the self-regulatory issue was her need to shore up her self-protection so that
she would not become engaged and trusting and then be betrayed. For my part, the self-regulatory issue was the management of anxiety and self-esteem in the face of these assaults. This underlying dilemma was never directly interpreted. To do so could only have been assimilated by the patient into her conviction that she was deeply flawed, irredeemable, and destructive. Instead it remained in the background as a dilemma that informed the interpretations and the ongoing interactive regulations of the treatment.

Loss and Intuitive Understanding

The patient had enjoyed an early relationship with a lively, adventuresome young housekeeper who helped take care of her from her birth until age three, when her sister was born. She preferred the housekeeper to her mother. The departure of the housekeeper left a void that ushered in a period of loneliness and hopelessness. When the patient was four-and-a-half years old, the housekeeper returned briefly. When the housekeeper left again after a few months, the patient was terribly disappointed. She believed that the housekeeper had come back to her to stay. She then attributed the housekeeper’s departure to some inadequacy and badness on her part. The emotional responsiveness and subsequent loss of the housekeeper helped lay the groundwork for her ever-increasing state of pessimism.

The patient described the housekeeper’s matter-of-fact manner as contrasting sharply with her mother’s emotional shallowness and pretenses. The housekeeper’s sudden, unexpected departure left her feeling uprooted and vulnerable. In the analysis, longings to find the housekeeper again and the dread of opening herself to a reexperience of loss were captured in the transference. A pervasive sense of depletion and depression fluctuated with her feeling responded to thoughtfully and “unpretentiously” by me.

A relatively stable mirroring selfobject tie, based on the early relationship with the housekeeper, enabled the patient to feel more alive, adequate, and valued. Gradually, she described feeling “better” during the analytic sessions. However, to reestablish this self-sustaining bond required that I infer, guess, deductively know,
intuitively understand her feeling states and the meaning of images from dreams or other experiences, without her associations. More active collaboration with me carried the danger of her participating in a self-betrayal.

Thus, in this portion of the treatment, the usual analytic exploratory stance needed to be altered. For me to persist in inviting her to communicate her thoughts would lead her to feel endangered, enraged, and unable to function. However, to treat her without her associations might lead me to feel endangered, enraged, and unable to function. She was asking for the kind of intuitive understanding that she had experienced only in spurs from the housekeeper. She pinned all her hopes on my being able to revive her vitality. I implicitly confirmed the necessity for such intuitive understanding, which had apparently been a critical experience for her with the housekeeper.

At times her demands were irritating. I could dispel this feeling by relating it to my expectation that I should provide her with what she needed and my sense of inadequacy about not consistently providing it. It was important for me to accept how wrong I was when I guessed and to acknowledge how off I was when I tried to approximate what I thought she was feeling. My acknowledgment that I was off was more important than being correct. Even more important, I was willing to try. Expectations of being understood, of affecting me, and of being affected by me began to emerge as a silent background. She struggled to remain sufficiently engaged with me so as not to scuttle the treatment.

On some occasions the patient would say, "Yesterday I said something very important. Do you know what it was?" I would immediately draw a blank. Sometimes I would say, "I don't know." My response proved to her that, although she had thought we were connected at that moment in the previous session, in fact we had not been. She had been wrong. She would then feel devastated, and our tie would be disrupted. Gradually, I came to understand this interaction as her way of both severing a connection that had become too intimate and retaining it at a lower temperature. Eventually, her questions could be interpreted as her attempt to prove to herself that a shared intimacy had been false, an illusion. She thus attempted
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both to recreate and to avoid a repetition of the attachment-de- sertion sequence that had occurred with the housekeeper. On other occasions, when I guessed successfully, she would provide more clues and maintain the connection, which would be temporarily repaired.
When I felt that the connection had become attenuated and she was silent, I experimented by musing aloud about my sense of frustra-
tion and puzzlement at not being able to reach her. These were both self-regulatory efforts and attempts to reach her by a different route. I also speculated about what she might be feeling—anxious, angry, taking pleasure in tantalizing me, or experiencing a despera-
tion about refining the lost housekeeper. When I asked how she felt about my musing out loud, she expressed delight, saying that she felt important. This interaction constituted an important mode of repair as well as a shared heightened affective moment, an oasis in a desert, so to speak. It gave us both a glimpse of a more overtly shared bond.
This section of the treatment, "loss and intuitive understanding," illustrates the joint construction of a new ongoing regulation. With me, the analyst, the patient revived her dilemmas: longing to be cared for and dreading that her "badness" would result in her being abandoned; and needing to remain overtly unwilling to associate lest she betray herself again. Thus, the ordinary expectable participation of the patient was not available. Instead, she required an altered form of treatment in which I was the one who provided the "correct" associations. There was nothing playful about the patient's request. It was her rigidly held belief that nothing less would do. Eventually it became clear that she feared that, by talking, she would reveal her badness, alienate me, betray her integrity, and destroy the relationship.
I understood this phase of the treatment as a shift to the estab-
ishment (or re-establishment) of a nonverbal bond based on the expecta-
tion that the patient could feel accepted and not abandoned. When I failed to understand her, when I guessed wrong, I was met with con-
tempt and rage. These reactions were eventually understood as her test to determine if the bond could tolerate her degree of "badness."
Thus a new ongoing regulation was constructed. The patient affected me by having me alter my usual way of working so that she
could stay in treatment without betraying herself through overt participation. In turn, I affected the patient by attempting to provide her with the requisite conditions that might enable her to experience a degree of hope. There was a possibility of rekindling in her the feeling of being accepted by the housekeeper.

However, the treatment often hobbled from one potential stalemate to another. I interpreted that, on one hand, she was extremely brave to tolerate danger at every step, on the other hand, she was desperately self-protective. She remobilized her dread of reenacting her "shallow" mother and her painful longings for the intuitive housekeeper. She feared that our intimacy might abruptly disappear. She was putting herself at risk to be with me, but her dread of retraumatization prevented her from taking advantage of this opportunity. This interpretive stance did not shift the intensity of her dread. We were continually on the verge of a disruption.

To extricate us from this dilemma, I had to alter my own self-regulation strategies. As she accused me of suffering from "terminal hopelessness," I had to dampen my enthusiasm and optimism. I concealed my expectation that I would actually help her. When I erred by misunderstanding her or by revealing my own "hope," she became enraged, sarcastic, and developed headaches. If I could tolerate her rage, we were back in business.

This section of the treatment demonstrates the delicate self- and interactive regulation required of both partners to be able to maintain this relationship. From the patient's side, mutual regulation was disrupted if she withdrew into physical complaints, or rages, which expressed only a small portion of the rage she claimed she felt. From my side, to avoid steering the treatment toward an impasse, I had to try to "guess," risk being wrong, tolerate feeling angry and inadequate, constrain my hope and enthusiasm, and acknowledge her fear that the intimacy had been false.

Complaints, Tests, and Acceptance

Approximately two years after the dread of self-betrayal was revealed in the analysis, the patient more and more frequently began her sessions by presenting a variety of complaints. The complaints illus-
trating herself through overt paternalism by attempting to provide that might enable her to experience the possibility of rekindling in her he housekeeper.

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dead of self-betrayal was revealed and more frequently began her symptoms. The complaints illustated both the presence of expectations of abandonment, apparently derived from the period after the departure of the housekeeper, as well as hopes for response.

The problematic aspects of her caregivers had contributed to these rigid expectations. The housekeeper had betrayed her through a sudden, unexpected departure. Her parents had betrayed her with their need that she affirm them as caring at the expense of her own integrity. Her younger sister had revealed in competitive triumphs over her. Nevertheless, her "complaints" in the analysis signaled that she retained some hope for responsiveness. Indeed, she feared that if she did not complain she might be taken for granted, found to be uninteresting, worthless, and then abandoned.

The patient complained that the analytic room was too hot, too cold, too stuffy, too bright, too dark. My chair was either too close or too far away. Or she would be unbearably thirsty or would suffer from a "migraine." Initially, these complaints were explored as communicating that she currently felt mishandled and anticipated further insensitivities. The patient's heightened sensitivity to variations in temperature, brightness, distance, or thirst states were understood as stirring up a sense of aloneness. She feared that she would be required to regulate her comfort on her own, by herself. I interpreted that she expected that now, just as in the past, she would be exposed to unresponsive, indifferent, intrusive, insensitive, or abandoning caregivers.

Before entering my office, the patient usually took her shoes off and left them in the waiting room. She explained that she felt more comfortable with her shoes off but worried that her feet smelled. Could I tolerate her with her smelly feet and her old, ugly, disgusting body? I realized that through this ritual she was revealing to me what she was most ashamed of. It was crucial that I recognize her silent question: Do you find me sexually repulsive? When she was silent during these sessions, it meant that she was waiting for me to ask her about her sexual feelings. This inquiry did not immediately provide insight into her unconscious fantasy life. Rather, the very fact that I inquired was pivotal. It meant to her that I was not turned off by her. In response, she would visibly relax. Through these interactions she felt that I was not avoiding intimacy with her.
of the lack of physical affection in her family then emerged, coupled with her own feelings of aversion toward her body.

The patient frequently brought a cup of water to the sessions. During one phase of the treatment it became clear that she wanted me to realize that she felt that she had to provide for herself. She stated that I had nothing to offer her. I learned that she was furious at me for offering her nothing but afraid to show me how enraged and sadistic she could be. She feared that I could not tolerate her rage.

Entering the analytic room shoeless and with a cup of water in her hand constituted a mutually organized ritual. My nonverbal acceptance of this pattern contributed to the stability of our connection. Acceptance required that I not interfere with any aspect of the ritual. Once, after she had arrived with the water a few times, I did question her about it. This inquiry was counterproductive. She told me that she would stop bringing the water if I was going to be so fussy.

My acceptance of the water, and of its meaning that I was not providing her with what she needed, made the subsequent dialogue possible. In retrospect, my acceptance of her ritual provided a necessary "background of safety" (Sandler, 1987). She required these concrete signs of acceptance of "unacceptable" aspects of herself. My noninterference in the ritual and my acceptance were my contribution to the interactive regulation. Her rituals were essential in maintaining her tenuous connection with me. They averted the danger of her retreating into sarcastic, despairing inaccessibility, with a suicidal potential. Over time the meaning of the various components changed, but the rituals continued.

In the earlier phases of understanding the meaning of the complaints, the patient had revealed the singular importance of my ability to guess, or to "know" intuitively, what she was concerned about without her associations. Any additional elaborations on my part were disruptive to her. When she felt "intuitively" responded to, she experienced a heightened sense of aliveness. Recognition of her needs, literal confirmation, and acceptance of her shame-ridden feelings constituted a central ongoing regulation. These literal confirmations were heightened affective moments for the patient. Her
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ve moments for the patient. Her
pessimistic state was momentarily transformed. She felt “known,”
“recognized,” “remembered,” “alive.”
Later in the treatment there was a substantial shift in the nature
of the transference. Her earlier requirement that I understand her
intuitively was transformed into a new expectation. I was now
required to make creative, illuminating, or even somewhat chal-
enging or confrontational interpretations. Exploration of her request
for this kind of intervention led to our understanding of a specific
dynamic meaning. It was not the content of the interpretations that
was important, but the fact that I could make them. Being the recip-
ient of these creative and challenging interventions revived her ex-
periences with her idealized, “phallic” father of puberty. Thus a new
theme emerged in the ongoing regulations.

The “Castrated” Father and the “Phallic” Father

By the time the patient reached adolescence, her successful physi-
cian father had become a barbiturate addict. From this time onward
she viewed him as “castrated” and “devalued.” These memories con-
trasted sharply with her earlier recollections of her energetic and
“phallic” father. We inferred that she had turned to her father after
the departure of the housekeeper. At that time her father had pro-
vided her with much-needed enthusiasm for some time until he, too,
became a disappointment.

The “castrated” father assumed the foreground of the treatment
when I failed to make illuminating and scintillating comments. In the
analysis, she expressed her disappointment openly, but in her fam-
ily she had held back her disappointment. She had not wanted to
join her mother in denigrating and humiliating her father. She needed
her father to be “tough.” He had indicated that he wanted her to be
“tough” by calling her “Rocky.” Although she tried to provide him
with the tough son she felt he wanted her to be, she failed. She felt
that he was disappointed in her. She believed that her father’s wish
for a tough son reflected his “castrated” condition. Whenever she
was able to experience me as distinct from her “castrated” father, she
was relieved. Then she did not feel like a disappointment, nor was
she obliged to become “tough” and sacrifice herself. Furthermore,
she did not then need to prop me up, a replay of her struggle to restore her father to his previously idealized, phallic position.

The following vignette illustrates the working through of the "castrated" father transference. As a session was about to begin, the patient announced in the waiting room that there were no paper drinking cups in the bathroom. I took a package of paper cups from a closet and placed them in the bathroom. As the session began, the patient said that she was furious. Once again, I had failed her. As on various occasions in the past, she questioned my ability to treat her. Placing the paper cups in the bathroom meant to her that I was unable to deal with her rage. She said that if I had not provided the cups, I could have demonstrated my ability to deal with her rage at having been deprived of the cups. This incident constituted a disruption in the ongoing regulation of our relationship.

During an earlier time in the treatment, when I did not agree to remove a cinder from her eye, the patient had been reminded of her parents' indifference. My uncooperativeness had confirmed her belief that I found contact with her body disgusting. This time, I felt it was appropriate to respond to her need. However, in retrospect, I see that, at this point in the treatment, I was silently serving as a source of (phallic) strength from which she could derive a sense of safety and protection. This strength would relieve her of the burden of having to protect me from her rage. She indicated that a lack of response would have been a demonstration of my strength.

In contrast to past experiences, as synopsized in the "picnic," the patient was able to talk about her rage and her fears, disappointments and criticisms of me, thus participating actively in the repair process. My supplying her with the cups had ruptured the selfobject tie, leaving her feeling vulnerable. It confirmed her expectation that her rage could not be tolerated. Our understanding of the meaning of the rupture constituted its repair.

Integration of Interactive Process and Dynamic Interpretation

The three principles address the interactive process per se. This process can be attended to either verbally or nonverbally and will always be interwoven with dynamic themes and their interpreta-
The Mismatch Between Hope and Despair: Disruption and Repair

The patient is in despair and I am experienced as too hopeful. She becomes enraged and mistrustful. I acknowledge that my helpfulness may have been too jarring for her. My comment recognizes that an affective mismatch has occurred. She continues to feel
hopeless and feels that she now has an analyst who may never understand her degree of hopelessness. I describe the whole sequence, and the ongoing regulation is retained.

Only later in the treatment could the dynamic content, the family stance toward the death of her horse, be linked to her experience of the jarring effect of my hopefulness. By fostering a pretense about the fate of the horse, the family did not acknowledge her despair. Making these connections too soon meant to her that I could not tolerate her despair and had to flee.

*Heightened Affective Moments*

The patient experiences states of rage or longing that she does not reveal. Intuitively, I correctly identify her state. She feels immensely gratified and hopeful. This sequence constitutes a heightened positive moment for both of us. Her state transforms from despair to hope. However, she wonders whether her states are really acceptable. I worry silently whether I can ever do this again. My silent worry damps my heightened affect. Only later in the treatment did I understand that my ability to intuit her state correctly was a refinding of the housekeeper.

At those all too rare moments in the analysis when her unverbalized expectations were met, she experienced a heightened sense of pleasure and satisfaction and felt deeply understood. These special moments were often based on my understanding of her yearning to be found acceptable. It was important to her that I did not need her to be “tough.” At other times, rageful, sadistic, vindictive intentions were at the heart of her complaints, dream images, or associations. My recognizing these states meant to her that I could accept aspects of her that were shameful and specifically censored within her family.

*The Transformation of Ongoing Expectations*

The patient feels hopeless and suicidal and threatens to quit treatment. I accept these feelings and do not flee. She feels understood and cared for. A complex interactive regulation is thus organized.
is an analyst who may never understand. I describe the whole sequence, named.

If the dynamic content, the familiars, be linked to her experience of absence. By fostering a pretense that the family did not acknowledge her at all, too soon meant to her that I had to flee.

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Expectations

Assicidal and threatens to quit treating do not flee. She feels understood.

For my part, I match her distress, but at a level of intensity just under hers. Thus I stay in her distress state without upstaging her, that is, without drawing attention to my own state. I am moved by her despair, accept my discomfort, and stay with her feelings. For her part, she accepts this intervention, feels in contact with me and enlivened. Later we came to understand that in her suicidal threats she anticipated an abandonment. My active acceptance of her feelings, without my trying to change them, came to mean that the dreaded abandonment would not occur. Moreover, the groundwork has been laid for expectations of a new form of interactive regulation.

The Integration of Dynamic Content and Interactive Process

In considering the integration of the interactive process and dynamic themes, we came to understand that this patient could not engage in the treatment in the way it is ordinarily conducted. The patient's pessimism and "resistance" to change interfered with her participation in the usual verbal therapeutic dialogue. Her specific fears and hopes dictated a narrow range of responsiveness into which she assimilated my interventions. When I "accepted" the patient's rituals and made descriptive interventions, contact was restored. Without special attention to the process of the interactive regulation, as well as to dynamic content, this patient would have consistently experienced me as confirming her depressed and hopeless feelings and her resistive style. Attention to the process of the regulation was continually integrated with recognition of dynamic themes, such as her dread of participation due to fear of self-betrayal and shame. She needed to have shameful aspects of herself recognized and accepted without having to say what they were.

Attention to the interactive process as well as to dynamic interpretation is critical to all phases of every treatment, although their balance differs from case to case. The loss of the housekeeper and the "picnic" provided a dynamic basis for the interpretive dimension of the treatment. However, we hold that attention to the process of interactive regulation is more than a preparatory phase for later interpretation. Attention to the interactive process implicitly accepts,
disconfirms, or alters aspects of the patient's expectations. It makes a major contribution to the patient's expectation of mutuality and being understood.

Although the dynamic interpretive activity made a substantial contribution, this patient was particularly responsive to the articulation of the interactive process. This articulation facilitated an increased self-regulatory capacity. Her manifest "complaints" became less intense and somewhat less frequent. She attempted to be more adventuresome in her life by permitting herself an occasional "extravagance" and in the analysis by increasingly revealing her shame-ridden fantasies. Most important, her ability to tolerate my lapses in understanding increased significantly.

At times this patient neither participated through her associations nor acknowledged my descriptive comments. Although she appeared to be "resistive," "unwilling to help herself," and "unwilling to make use of the treatment situation," we have shown that, instead, she was an active contributor to the process of change. Her continued engagement in the treatment was evidence of the success of this attention to the interactive process.

The clinical material described was drawn from the first five years of the treatment. At that point, toward the end of the fifth year, if the patient were asked what she had derived from her analysis to date, she would probably have answered, "Nothing." Yet her attendance was impeccable, and she was consistently responsive to me. Alterations in the schedule of analytic hours disorganized her and increased her sense of hopelessness, attesting to a viable self-object tie. Not until the seventh year of analysis was overt acknowledgment of its importance possible. Not until the eleventh year was termination possible.

Summary

In studying the dyad as well as the regulation of the individual, infant research brings to psychoanalysis the perspective of the system. This perspective explicates the individual's subjective experience within the dyad and the dyad's impact on the individual's experience. Thus, actions from the cosmeticization of the system are active processes, dynamic in nature.

A central concept of analytic action as a co-creative moment to manifest the concept of interplay between expectations of change, hope, as well as moment, both active and passive. The interpretive, verbatim contribution...
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Summary
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e experience. We used three principles of the organization of inter-
actions from infant research to suggest a differentiated conceptual-
ization of the analytic relationship and modes of therapeutic
ction. Using one case, we illustrated how attention to the in-
active process through the three principles can be integrated with
dynamic interpretations.
A central contribution of infant research is its description of inter-
action as a continuous, reciprocally influenced process, constructed
moment to moment by both partners. The application of this con-
cept of interaction to adult treatment enriches our view of thera-
peutic action. At every moment, there is the potential to organize
expectations of mutuality, intimacy, trust, repair of disruptions, and
hope, as well as to disconfirm rigid archaic expectations. At every
moment, both analyst and patient contribute significantly to this
organization. Everything the analyst does, interpretive and nonin-
terpretive, verbal and nonverbal, exploratory and descriptive, poten-
tially contributes to the organization of the patient's experience.