The direct links among early development, a model of the mind, and the content of the transference are challenged from two vantage points—empirical infant research and motivational systems theory. A discussion of these contributions and of their application in two case vignettes suggests a new view of therapeutic change—a view involving (a) recognition of the coconstruction of the analytic relationship, (b) contributions of self and interactive regulations, of their disruption and repair, and of heightened affective moments to the ongoing analyst—patient interchange, (c) emphasis on the analyst's recognition of the patient's communications as developmental strivings, (d) tracking of sequences of disruption and repair, and (e) dialectic between repetition and transformation. These various interactions develop in a patient new expectations of being understood, of being understandable, and of participating in a dialogue that does not, for example, require bolstering the other or sacrificing oneself to the other. These new expectations lead to new themes as well as to the transformation of old themes that organize experience.

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When I began my psychoanalytic training, I learned that psychoanalysis posited a blueprint for development, a model of the structure of the mind, and a theory of treatment based on the analysis of transference. The links among these three domains—development, structure, and transference—guided treatment (Lachmann and Beebe, 1992). I learned that the infant was all id and that attachment to objects proceeded through drive satisfaction. When the environment curbed the drives, what had been id became ego. Development and the structure of the mind were thereby directly linked. For psychopathology, conflict among the structures of the mind eventuated in symptomatology. These conflicts, when transferred by the patient to the analyst, could then be analyzed and resolved. That was the link between structure and treatment. Or, as Mahler (1971) observed, when a patient switches among grievances, rage, and admiration for the analyst, these transfers can be attributed to formative experiences during the separation-individuation phase. In such instances, interpretations would focus on projection and on splitting or failure to integrate good and bad images of the mother—illustrating the links among transference, early development, and the organization of the mind.

In addition to learning about Freud's id infant and Mahler's symbiotic infant, I also learned that Melanie Klein's infant was a little demon, a demonic infant, ready to gouge out its mother's inwards. Through projective and introjective mechanisms, this demon could be civilized, feel guilt, and reach the depressive position. I watched the pendulum of early development swing in the other direction—the infant as totally molded by the environment. This was the era of the environmentalist infant, the infant as tabula rasa, shaped and mishapen by experience. Now we are in the era of the constructionist infant, the infant coconstructing its world in interaction with its environment. This is the infant conceived by empirical infant researchers.

The direct links among early development, a model of the mind, and the content of the transference had been challenged from many quarters (e.g., George Klein, 1959; Gill, 1982) before the advent of the empirical findings. However, empirical infant research dealt three telling blows. First, if the infant coconstructs its world with its caregiver, then the infant is “attached” from birth. Attachment does not have to be acquired. The infant brings its own organization
into the caregiver—infant dyad (Stern, 1985). Second, the mind does not develop in isolation but in a relational matrix through dyadically organized processes (see also Stolorow and Atwood, 1992). Third, just as infant and caregiver coconstruct their world, so do analyst and patient. And, just as in the infant—caregiver dyad, in the organization of the transference the partners' contributions are neither equal nor similar (Beebe and Lachmann, 1994). Therefore, transference cannot be thought of as a direct display of the patient's unresolved conflicts but as coconstructed by analyst and patient (Stolorow and Lachmann, 1984/1985).

Crucial to these revisions of psychoanalysis as a theory of development and treatment and as a model of the mind are the concepts of coconstruction and transformation. In the process of development, at each moment in time, the infant affects and is affected by its environment. At the next moment in time exist a slightly different infant and a slightly different environment. Through their interaction, both infant and environment are transformed (Sameroff, 1983). Transformations range from increased rigidity in, for example, pathology (as in cases of neglect, abuse, or trauma) to increased flexibility in accessing and using one's resources in self- and interactive regulation.

A transformational model shifts the paradigm for development. We have moved from a theory of sequential phases of libidinal development to a theory of continuous construction, as in Stern's (1985) depiction of the development of the senses of self. We have moved from a clinical model that emphasizes a repetition compulsion to a model that sees repetition and transformation in a dialectic. We now have an infant shaping and shaped by its environment. Thus, we have moved toward an extraordinarily complex model of the mind, of development, and, consequently, of treatment. We have moved toward a developmental model that accounts for simultaneously maintaining a sense of one's continuity while undergoing continuous transformations. We have moved away from the constructs of structure and toward the constructs of processes and systems, of a person and an environment (infant—mother, patient—therapist) who influence and coconstruct the experience of the other with the other (Stolorow, 1997; Lachmann, 1998).

As psychoanalysts, we now have to contend with two models of early development. Traditional psychoanalysis, largely derived from retrospective reconstructions of early development through the analysis of adult psychopathology, produced the “clinical infant” of Freud, Mahler, Melanie Klein, and others. Direct observations of normal infants produced the “empirical infant.” Rather than using the vocabulary of traditional psychoanalysis, these “baby watchers” speak in a “new” language, the language of developmental and cognitive psychology. They use terms that are new to psychoanalysis—for example, expectancies. The new terms heighten the differences in the vantage point of the two perspectives. However, Stern (1985) argued against abandoning the constructs of the clinical infant. He holds that we need both models of infancy in our clinical work.

The empirical infant research depicts a related infant with an enormous array of inborn capacities, such as detecting contingencies between events and translating experiences from one sensory modality to another. It provides us with a basis from which to infer the development of psychopathology. Most important, it has sensitized or resensitized us to the ongoing, often nonverbal and unverbalized dimensions of the analyst—patient interaction.

For adult treatment, the clinical infant provides rich metaphors that depict the subjective, encoded history and experience held by adults about their development. The clinical infant is heavily influenced by specific psychoanalytic theories in depicting how development went awry and how that was experienced by the person. In embracing both infants, we are in a better position to ask what the consequences for psychoanalytic theory and treatment are when we include a developmental theory that is based on observations of normal and not pathological development?

Such questions and shifts capture the essence of the contributions with which the empirical infant research challenges psychoanalysis. A new database has emerged from the mushrooming of studies, observations, and experiments involving normal infancy. My colleagues Beatrice Beebe, Joseph Lichtenberg, and James Fosshage and I claim that these studies make a profound difference to the practicing clinician.

My collaborations with Beebe and my collaborations with Lichtenberg and Fosshage actually embark from different ports. The point of departure for Beebe and me is the microanalytic, frame-by-frame analyses of mother—infant face-to-face interactions in the third to fourth months of life, when the capacity for sustained visual engagement has become reliable. We have been examining the vast research on the infant—caregiver dyad and have identified three organizing principles of the infant's experience—ongoing patterns of self- and mutual regulation, disruption and repair of ongoing regulations, and heightened affective moments (Beebe and Lachmann, 1994; Lachmann and Beebe, 1996).
Central to these three principles is the concept of expectancies. Infants detect order, repetition, and predictable consequences following their own actions. The confirmation of expectancies yields predictable “ongoing” regulations. The violation of expectancies yields disruptions that range from playful and pleasurable to traumatic and difficult to repair. The three organizing principles and the confirmation and violation of expectancies operate throughout life and can also be applied through metaphor and analogy to the psychoanalytic treatment of adults. Our understanding of therapeutic action in adult psychoanalysis is thereby enhanced.

In my training, I learned to think of adult psychopathology in terms of its infantile prototypes. In surveying the empirical infant research, I have been struck by the profound differences between the normal infant and the neurotic or “borderline” adult. The link between adult pathology and normal infancy—as in the concept of developmental arrest—I now find to be highly questionable. Adult pathology can never be said to have been “normal” at any age. However, Beebe and I have proposed links between normal infants organizing their experience and adults organizing their experience both inside and outside psychoanalytic treatment.

Lichtenberg, Fosshage, and I embarked on our journey of exploration from the vantage point of the adult psychoanalytic setup (Lichtenberg, Lachmann, and Fosshage, 1992; 1996). Although we used infant studies in the formulation of the five motivational systems, which I discuss later, the development of a theory of treatment has been our primary concern. Specifically, by casting our findings from infant research into principles for the conduct of adult psychoanalytic treatment, we have sought to enlarge, modify, and extend self psychology with respect to technique. Concepts such as model scenes and tracking the patient's affect illustrate the approach from this vantage point.

Eventually, the two approaches—from empirical infant work and from the adult analytic situation—should meet. The principles of organization of experience and the model of development derived from the infant studies should connect with the assumptions about the organization of experience derived from adult psychoanalytic treatment. Furthermore, the developmental model should connect with a theory that explains how psychopathology develops. At present, some connections are in place, but there is still a long way to go. In the present discussion, I focus on how far we have come and on where we can apply what we have learned. This is work in progress in a field that is constantly and fascinatingly evolving.

I have gathered some contributions from the empirical infant literature that my colleagues and I have discussed and that I believe have affected the conduct of adult treatment. First, the stance of the analyst vis-à-vis the patient is shifted. Empirical infant research challenges both the reconstructed infant and the associated pathology-based model of development that analysts have traditionally used (Beebe and Lachmann, 1988a, b, 1994; Lachmann and Beebe, 1992; Beebe, Lachmann, and Jaffe, 1997). Attention shifts from a predominant interest in what went awry in the patient's life to the patient's transformational efforts in a dialectic with repetitive patterns.

Vicissitudes of self- and interactive regulation come to the fore (Beebe, Jaffe, and Lachmann, 1992; Lachmann and Beebe, 1996). Transference is understood to encompass the ongoing organization of the patient's experience of the analytic relationship (Stolorow and Lachmann, 1984/1985), coconstructed by both analyst and patient (Lachmann et al., 1992, 1996). The coconstruction of model scenes by analyst and patient provides an entry into aspects of the patient's experience that had previously been puzzling and unclear (Lachmann and Lichtenberg, 1992). The frame-by-frame analysis of mother—infant interactions serves as a model for the close attention to the continuously shifting details of analyst—patient interactions in adult treatment, including their nonverbal communications (Beebe and Lachmann, 1994; Lachmann and Beebe, 1996). Finally, the theory of motivational systems provides analysts with a broad map for capturing the patient's experience. In toto, as I illustrate here in two clinical vignettes, these contributions of the empirical infant researchers affect the stance of the analyst, the ambience of the analysis, and, specifically, the analyst—patient interaction.

To discuss each of these contributions in detail, individually, would fail to take advantage of their overlap and natural “groupings.” To do justice to the complexity of the striving and self- and interactive regulations and the variety and complexity of contexts, I continue to discuss them in narrative form rather than to illustrate each individually and separately. I have already alluded to some of these contributions—the organization and coconstruction of experience in infancy and the transformations of that experience.

As Stern (1985) proposed, there is no early phase of development in which infant and caregiver are not in a “relationship.” At no time can the infant be described as living in a normal “objectless” or autistic state. Certainly there are adult patients, those diagnosed with borderline or narcissistic pathology, who can be described as having

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failed to separate from a primary caregiver or as being unable to form attachments. Those are patients whose sense of self is diffuse or who suffer from extreme dependency needs and readily melt into a merged state with another person. However, we can no longer assume (a) that this pathology reflects the retention of a normal early state of self—other merger, a state to which the person has held on too long, and (b) that this pathology invariably originated in the earliest phases of development. Pathology such as an inability to recognize the separateness of the other, indifference toward other people, or being prone to dissociation is not indicative of the retention of a normal developmental phase. In fact, such pathology cannot even be presumed to have originated in very early phases of development. Such assumptions have tended to make us probe, sometimes relentlessly, for a preverbal basis of a patient’s pathology to the neglect of the significance of later events in a patient’s life.

In 1980, from our reading of Freud, Mahler, Jacobson, Kernberg, and Kohut, Robert Stolorow and I (Stolorow and Lachmann, 1980) formulated three tasks that the developing infant has to fulfill: (a) learn to differentiate representations of self and object, (b) overcome the initial split of images of all-good and all-bad objects and integrate these into whole representations of one object that is sometimes good and sometimes not so, and (c) establish self- and object constancy. Before the advent of the empirical studies of infancy, these three tasks were part of the accepted model of early development and postulated the origin of adult pathology.

In 1991, infant researcher Lyons-Ruth pointed to the logical contradiction between positing that, on one hand, the infant must learn to differentiate self from other because initially self and other are presumed to be merged and that, on the other hand, the infant must learn to perform the opposite task, to integrate good and bad object representations, because these representations are assumed to be “split” at birth. Lyons-Ruth (1991) stated,

The ambivalent, angry behavior alternating with positive behaviors, which would appear to be the hallmark of such an underlying psychological organization, are not prevalent among infants prior to 15 months of age during the time when these “split” object representations are hypothesized to exist.... [T]hese ambivalent angry behaviors become increasingly prominent among children at serious social risk. Thus, the developmental evidence is more congruent with the notion that,

under conditions of adequate caregiver regulation, the infant develops smoothly integrated behaviors patterns and representations, involving both positive and negative components. By contrast, when caregiver regulation is inadequate, the infant develops increasingly well-articulated and distinct negative representations of self and other, which are poorly integrated with representations of positive interactions.... Poorly integrated positive and negative representations are not intrinsic to early infant functioning, but a gradual developmental acquisition under conditions of disturbed regulation [p. 13].

When Lyons-Ruth reexamined the films made by Mahler, she concluded that, in naming a phase separation-individuation, Mahler (Mahler, Pine, and Bergman, 1975) based her nomenclature more on her theoretical heritage than on the behavior of the infants. Lyons-Ruth proposed renaming this phase of development attachment-individuation, because she observed far more evidence of the continuing attachment behaviors of Mahler’s toddlers than of “separation” behaviors. Her proposal is consistent both with a rarely advertised idea of Mahler's (that symbiotic needs are really lifelong) and with Kohut's proposal that the need for selfobject experiences is lifelong. The implication for adult treatment is that attachment and separation are not necessarily in conflict but work cooperatively with each other. Autonomy and self-assertion, and individuation with a distinct sense of self, do not develop through separation from a primary caregiver but require retention of the attachment. Through its retention, an attachment can be gradually abstracted. The person thereby becomes capable of forming attachments to persons other than their primary caretaker. The capacity for attachment then becomes more generally applicable. Furthermore, through its retention, an attachment to a primary caretaker can become increasingly depersonified, so that the literal presence of the primary caregivers is less and less necessary for sustaining the sense of self. The role of the transference in furthering the abstraction and depersonification of a primary attachment is illustrated in the following vignette.

A 39-year-old divorced woman (discussed in greater detail in Lachmann and Beebe, 1992) had, after considerable time, established an idealizing selfobject transference with me in her analysis. Much of the content of the sessions of the prior years of analysis dealt with her

tendency to establish masochistic relationships. She would become the caretaker of others, then feel victimized, angry, and exploited. She complained resentfully that she was always having to adapt to someone else’s agenda. In the course of our work, she eventually sought a better job. In describing a promising job interview she had, she told me that it went particularly well because she thought that the interviewer and I knew each other and that therefore the interviewer had
been particularly receptive to her. I knew of no such connection and thought that attributing the positive interview to me and my influence constituted yet another attempt on her part to disavow evidence of her competence and independence. It sounded to me like another instance of her masochistic self-devaluation. So, I interpreted her reluctance to accept her competence and skills as accounting for her attributing her success to me.

At this point in the analysis, in response to my interpretation, the patient was able to say, “Look, you make sure that our tie is retained, and I’ll take care of my own autonomy.” We then proceeded to find the “kernel of truth” in her attribution. It was indeed my presence through her feeling of connection to me—her continued tie to me—that had enabled her to have such a successful interview. I had interpreted her report far too literally and thereby threatened to rupture the connection.

Previously, in the analysis, the most frequent ruptures of the selfobject tie had been when I jarrad this patient's need to feel my investment in retaining our tie. Through our prior work, her self-expectations, and her expectations of me, had been transformed. In the present instance, she was able to initiate restoration of the rupture. I contributed toward restoring the disrupted tie by recognizing the validity of her feeling that she had me with her at the interview. Her playful comment, a heightened affective moment for both of us, was evidence of the transformation of her fragile self-organization into a more cohesive one in which she could access a sense of humor. Her attachment to me had become less concrete. It had become abstracted so that she could “take me with her” and feel my presence at the interview. Her ambitions and her ability to be more competitive and assertive flourished. But, in her attachment to me, I had not yet become sufficiently depersonified. In taking me along to the interview, she still required my participation. I was still required to make sure the tie was retained. Her playful comment to me signalled her greater resiliency and autonomy.

Had this interaction occurred after I had become more familiar with the dialectic between repetition and transformation, I might not have focused solely on the grip of her masochistic pattern, a pattern that she and I knew related to her early attachment to her mother. That is, I might also have acknowledged the transformations that had taken place in the course of her analysis.

Repetition of a masochistic attachment referred to the patient’s dread of being abandoned by her mother, who had been preoccupied with the care of her own parents and sisters. To ensure her overburdened mother's attention, the patient constrained herself and became an undemanding though resentful caretaker. She thereby staved off expectations of being abandoned. Later, during puberty, the patient—with her masochistic tendency and self-organization—underwent a crucial transformation vis-à-vis her father.

Until the patient reached puberty, her father had been a courageous, politically active figure, somewhat romanticized by her and her political cronies. He was seen as strong and charismatic. Her attachment to her idealized father lifted her out of the masochistic attachment and the depressed world of her mother.

The patient recalled being taken by her father to his political meetings. There lifted her up high and set her down on a table on the platform from which he addressed the group. She felt exhilarated sitting there with him, and she watched him in awe during the meeting. Afterward, he again swept her up and set her down. To be raised to this height by her father—with its attendant feeling of exhilaration—emerged as a model scene for the treatment. The model scene captured her experience of exhilaration when her father was at the height of his powers and showed her off. She felt that she shared in his triumph. However, this experience also previewed a letdown. The immediate letdown was the return home to the depressed mother. Later, there was an additional letdown. Toward the end of her puberty, through “misjudgments” on his part, her father saw his fortunes and his standing in the community plummet.

The patient experienced her father's decline as a devastating blow. To sustain herself, she imagined that she could restore him to his previous glory and, most important, that he needed her to do so. Then she could again share in his power and protection and feel the excitement and security that she enjoyed before his decline. With this idealized tie to her father in place, she could retain and access the resources she had acquired through him. These resources included a broader vision of the world, the “view from the platform,” and a range of intellectual and social values. Her father's warmth and openness to cultural and sensual interests (e.g., music, art, food), as compared to her mother's severe limitations, opened a new world to her.

The sustained idealizing selfobject transference of the early years of the analysis derived from the patient's tie to her idealized father. So long as she felt that I was a source of strength and power that she could share, treatment could proceed. She thereby gradually reacquired and reaffirmed the legacy of her father's resources. For the idealizing transference to have been sustained as successfully as it was, my acceptance of and even liking to be idealized contributed to the patient's opportunity to establish this transference. My acceptance of the patient's idealization was my nonspecific
contribution to the transference through which she restored her sense of competence and reacquired resources that enabled her to seek the better job.

The patient's resources, intrinsic to her self-organization, were sustained by her initial fantasy—that her father needed her—and by her new fantasy that, in treatment, I needed her to maintain me in a preeminent position. She felt capable and could function so long as she felt sure that I needed her to sustain me. In the course of the analysis, when I made interventions that indicated to her that I did not need her to take care of me (as illustrated by my interpreting her self-sacrifices as masochism), this idealizing transference was ruptured. Subsequently, through these ruptures, the nature of the tie, its history, and its role in the transference were clarified. For example, in the course of these explorations, we discovered that my comments about her self-sacrifice meant to her that I did not need her to sacrifice herself for me. Furthermore, my “misjudgment” in making such interpretations revived her disappointments in her father's misjudgments.

In assuming that the transference is coconstructed, I assume that the disruption of the transference is also coconstructed. The disruption is not a consequence solely of the patient's pathology, her negative therapeutic reaction, my theory, the countertransference, or the failure of empathy. It was through a detailed inquiry, akin to a frame-by-frame analysis of the mother—infant interactions, that we discovered the extent to which she needed to bolster me so that she could feel secure and competent.

Disruptions of the self-object tie, or ruptures in the empathic bond, cannot be avoided. No matter how tactful, careful, or sensitive an analyst may try to be, disruptions occur and are essential in bringing to light the specific vulnerabilities of the patient's sense of self.

A second difficulty with my interpretation was how literally I heard the patient's account of her job interview. Why did I do that? I can consider several personal issues here. Did I respond too concretely because I was anxious? Did I become anxious because I felt the patient was reverting to an old pattern, and years of analytic work were about to unravel? Was I made uncomfortable by the extent of this patient's idealization of me? Did I like the idealization and become uncomfortable because I liked it? In listing these possibilities, I am speculating about some of my contributions to the construction of the transference and to its disruption and repair. I discussed none of these with the patient, and I do not believe that such disclosures need to be made. I do not believe that these personal themes were pulled forth, induced, or projected into me by the patient. Such conceptualizations of the transference—countertransference assume a perspective in which the patient is held responsible for both the transference and the countertransference. I believe that I bring to the transference certain organizing principles of my own. My themes are instrumental in shaping the patient's transference just as hers are in shaping mine. Each patient will activate and contribute toward shaping various aspects of these personal themes.

In discussing this case, I have referred to a model scene that the patient and I coconstructed—being lifted onto the platform and sharing in father's idealized strength. When the patient recalled the experience, I understood it as capturing her affective swings in relation to me, her relationship with her parents, and her character style of striving to be “on the platform with her father,” which isolated her socially and alienated professional colleagues.

Model scenes are metaphors (Lachmann and Lichteberg, 1992). They can be derived from early experiences, but not exclusively so. Events in a patient's life, dream images, or even scenes from literature can provide model scenes. They may picture a character style, a relational theme, or a transference interaction and thus may clarify what may have seemed puzzling. They can be derived from any age of the patient.

The concept of model scenes is an extension of Stern's (1985) RIGs—"representations of interactions" that are generalized. RIGs can be organized through an accumulation and “averaging” of experiences (Stern, 1988) and through specific lived experiences such as heightened affective moments and trauma. They are also subsequently subjectively elaborated, through fantasy and defensive elaboration,

and are further transformed in the processes of growth and development itself.

A close relationship between representations (as in RIGs) and internalization now becomes apparent. Unlike theories that emphasize frustration in one form or another as the royal road to psychic structure formation, nonfrustrating experiences as well as ongoing interactions and “noninterpretive” interventions lead to the elaboration of an inner world of expectations and restraints.

The model scene of being lifted onto the platform represented a heightened affective moment between the patient and her father. It is an elaborated RIG derived from recollections of the patient that were relatively unique in the course of her daily life. The memory and its associated affect were elaborated with a multitude of meanings. Capturing these themes in
graphic, pictoral, and metaphorical form enabled us to make sense out of transference ruptures, such as my letting her down, which, without this perspective, had been quite puzzling.

In another case, a patient lying on the couch suddenly began to experience an unpleasant tingling in his legs. We explored the context of the session in which this tingling occurred. After the tingling reoccurred in several sessions, the patient reported that, based on some change he perceived in my breathing, he felt that I was about to say something. Just before, we had both been silent. An exchange based on the meaning of sounds had taken place without either of us having been conscious of it. Through his description of his feeling state and the particular quality of his discomfort, I used his tingling and his position on the couch to construct a model scene.

The patient lay on the couch. His feet, extended, tingled and trembled. I said that he resembles a baby, lying on his back in a crib, who wants to be picked up. On hearing approaching footsteps, the baby might feel an anticipatory excitement that he is about to be picked up—in this case by his father. But then the footsteps continue past his room and he is left alone in his aroused state.

We had no idea whether this experience ever actually occurred in his life. We did not attempt to reconstruct an event; instead, we tried to construct a metaphor that captures this patient's bodily experience of expecting to be picked up but being ignored. The scene captured a salient dimension of his general anxiety and clarified his experience in analysis. Similarly, we really do not know whether the patient previously described was ever lifted up onto the platform by her father

in the manner she described. The actuality of these events is not as significant as their organizing implications. That is, they describe in graphic form themes that organize life experiences, symptomatology, and dominant transference configurations.

Exploring the model scene of the patient who “wants to be picked up” clarified his ever present expectation that he would be ignored. He characteristically anticipated that he would become excited and then left to regulate his excitement on his own. We came to pay particular attention to moments in the analysis when he expected something to be forthcoming from me, but instead I waited too long, hesitated, or did not find anything to say. After we explored the model scene, he did not experience the tingling again.

Tracking this patient's distress affect enabled us to identify what sent shivers into his feet. He dreaded alienating others. He felt that, were he to express his expectations and disappointment, he would ruin all possibilities of gaining attention. Reactively, he became overly compliant and dealt with his suppressed disappointment by himself. As his analyst, however, I was not required to speak more, faster, or less hesitatingly. Rather, we explored instances when his affect reflected a subtle sense that he was being left in the lurch by someone whose attention he desperately craved.

This patient described himself as helpless and unable to regulate his own distress state. He described others as self-preoccupied and unattentive toward him. These affect-laden descriptions of self and other were organized in line with facets of the current analyst—patient interaction and included expectations derived from earlier times. Such expectations were then rigidly repeated and imposed on current experience. Optimally, expectations are flexible. They transform and are transformed by ongoing experience. Investigation of expectation of being responded to, ignored, and then having to regulate one's own excitement can be drawn into the analytic dyad. In addition to interpretive interventions, the ongoing analyst—patient interaction, part of the transformative process that is in a dialectic with repetition, organizes “new” expectations of being understood and responded to.

With Beebe, I have described how the cataloguing of the array of infant capacities provides a richly detailed world of self, other, and their interaction. I now turn to the other entry into the contributions of infant research to adult psychoanalysis—the work I have been doing with Lichtenberg and Fosshage.

The array of infant capacities catalogued by the baby watchers has also led to the development of a motivation theory that assumes five distinct motivational systems. The five motivational systems are the need for psychic regulation of physiological requirements, the need for attachment and later for affiliation, the need for assertion and exploration, the need for sensual pleasure and sexual excitement, the need to react aversively through antagonism and/or withdrawal. Each of these systems is based on behaviors that are clearly observable beginning in the neonatal period. Each system is based on mutually regulated, inborn needs. Each system is designed to promote the fulfillment and regulation of a basic and fundamental need.

During infancy, each system contributes to self-regulation in interactive regulation with caregivers. At each period of life, the wishes, desires, aims, and goals that derive from needs in each motivational system may be rearranged in different
hierarchies, indicated by different conscious and unconscious preferences, choices, and proclivities. From moment to moment, the activities of any one system may be intensified to the point where it provides motivational dominance for the sense of self.

In the case of the woman who “took care of her own autonomy,” a shift in the hierarchy of her motivations occurred in the course of her analysis. When she began treatment, her motivational priorities centered on maintaining attachments at the expense of assertion and exploration. To maintain her feeling of inclusion in her father’s world, she sacrificed assertion of her preferences and reacted averingly, with suppressed feelings of resentment. Furthermore, she withdrew from competitive situations that could indicate that she was self-sufficient and did not need anyone. Yet, in maintaining her tie to her father, she also kept alive her curiosity about the world and her capacity for sensual enjoyment. Sexual pleasure, however, was problematic because it entailed, for her, a degree of self-assertion that threatened her need to maintain her father in an idealized position. In the course of her analysis, she began to feel more secure about her attachment to me. In turn, she became more assertive, ambitious, and competitive.

For a considerable period, interpretations of her suppressed resentment shattered her selfobject tie to me and produced serious disruptions in her life and her treatment. Recognizing the nature and context of the disruptions restored the tie.

The selfobject dimension of the transference articulates the extent to which a patient’s experience of the analyst gradually accrues to the

patient’s self-cohesion and vitality. Beebe and I (Lachmann and Beebe, 1992, 1995a, b) have expanded this view of transference by according equal recognition to a representational dimension that encompasses varieties of relational experiences. When the selfobject dimension is intact and in the background, the themes contained in the model scene occupy the foreground of the transference. This representational dimension of self, other, and their interaction, often depicted in model scenes, can then be investigated.

In the case of the patient whose feet tingly, a mirroring selfobject tie had been established. In the course of the analysis, he was gradually able to experience a sense of bodily and psychic cohesion. The disruption of that selfobject tie left him with feelings of disorientation and helpless with respect to his self-regulation. Understanding the nature of the disruption restored the tie, and the tingling receded into the background. Then the representational aspects of this patient’s transference, his fear of alienating those by whom he wanted to be picked up moved into the foreground.

A new view of therapeutic change now emerges. This view can be inferred from six themes: (a) emphasis on coconstruction, (b) contribution of the ongoing analyst—patient interchange, (c) the recognition of developmental strivings, (d) tracking of sequences of disruption and repair, (e) organizing potential of heightened affective moments, and (f) dialectic between repetition and transformation. These interactions lead to new expectations of being understood, of being understandable, and of participating in a dialogue that does not require bolstering the other or sacrificing oneself to the other. These new expectations lead to new themes as well as to the transformation of old themes. I assume that old themes never disappear and that they cannot be “renounced.” They remain but become less dominant alongside the newly organized ones. For example, newly organized themes such as “I can expect to be understood and attended to” to capture the reconfiguration of the attachment and assertion motivational systems. Previously encumbered and unavailable motivations can then be enjoyed—for example, exploration and assertion in competitive situations, sexual excitement, and attachments without self-sacrifice.

Why do I believe that the psychoanalytic theory that is emerging from empirical infant research and the five motivational systems is preferable to other, psychoanalytic theories? First, the emerging theory is derived from normal development. It establishes baseline assumptions about the potential availability of a variety of motivations without reducing behavior to one or two drives. Furthermore, it

provides finer categories—including recognition of nonverbal communication—with which to explore therapeutic interactions. Finally, this emerging theory recognizes the analyst—patient relationship as the system that affects therapeutic action.

As does any theory, this emerging theory tilts clinical interventions in a particular direction, toward acknowledgment of developmentally acquired resources all along the age continuum. Using the transformational view of development, the origin of pathology is not reduced to the earliest years of life, and the early mother—child relationship is not posited as the bedrock of all pathology. A patient’s organizing propensities, and the potentially decisive influence of experiences from early childhood to puberty or even later, are recognized in model scenes. In both model scenes coconstructed in the case illustrations, the patient’s father figured as the significant participant. One scene, derived from the meaning of sounds,
captured a long-standing theme in the patient's relationship with his father. The other scene was derived from the patient's puberty years, when the patient and her father organized an experience of uplift and descent.

With my colleagues Beebe, Lichtenberg, and Fosshage, I have been explicating two distinct but related systems perspectives—self- and interactive regulation and the motivational systems. Although the two systems perspectives differ in their level of abstraction and in their relationship to empirical data, together they offer a unique contribution to the treatment of the difficult-to-reach patient. In these treatments, the interaction between analyst and patient requires especially close, continuous attention. The developmental model derived from empirical infant studies offers patterns of interaction that direct our attention beyond the usual verbal exchanges. The research also provides metaphors and analogies that contribute to the construction of model scenes and expand our understanding of the analyst—patient interaction. In treating the difficult-to-treat patient, attention to the process of treatment, analogous to a frame-by-frame analysis of infant—caregiver dyads, carries the therapeutic leverage.

In studying the neurobiology of motivation, Hadley (1989) proposed a hierarchy of ways in which the brain processes information. Familiarity and novelty cover repetition and transformation as well as motivations in response to needs for assertion and exploration; maintaining arousal within tolerable limits includes self- and mutual regulation within the needs of both caregiver and caretaker for attachment; and pleasure

and pain include motivations in response to needs for physiological regulation, sensual pleasure, sexual excitement, and aversive responses such as antagonism and/or withdrawal. I believe that empirical infant research has showered us with novelty and challenged our tendency to seek the familiar. For psychoanalysts, the familiar is too often linked to the pleasure of complacency, to cling to the known and to turn our back on the “new.” Yet, we are also neurologically primed to be curious and explore. Let's learn from the infants we are studying and seek novelty, hold onto the familiar, hold onto our repetition principle, while we invite new experiences and new data to transform our theories of development and the clinical practice of psychoanalysis.

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