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**The Unspoken Dialogue: An Exploration of the Role  
of Ongoing Self- and Mutual Regulation in the  
Formation of Psychic Structure**

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## ABSTRACT

This dissertation uses theory derived from empirical infant research to illustrate the role of ongoing patterns of self- and mutual regulation in the formation of new expectations and organising principles – that is new psychic structure. Views on the nature of psychic structure and the process of structure formation, are considered from the perspectives of self psychology, intersubjectivity theory and the findings of infant research. The position that frustration and disruption is central to structure formation is contrasted with the view that structure is formed through a multiplicity of routes. Clinical material drawn from a therapy with an eight-year-old child is used to illustrate one particular salient principle of structure formation, ongoing self- and mutual regulation. The concepts of self- and mutual regulation proved invaluable in understanding the nonverbal patterns of interaction which emerged during the course of a therapy with a child who struggled to use symbolic play or words to convey her inner experience. The focus is on the micro-analysis of the patient's and therapist's patterns of self- and mutual regulation and the role of each partner's subjectivity in co-constructing the therapeutic relationship. This dissertation argues that ongoing patterns of self- and mutual regulation constitute therapeutic action and play a central role in the creation of alternative organising principles. The contributions from infant research have led to a paradigmatic shift in psychoanalytic theory, which has significant implications for our understanding of therapeutic action, technique and models of training.

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## CHAPTER ONE

### INTRODUCTION

Psychoanalytic psychotherapy is essentially concerned with psychic change and the processes that effect this change (Ghent, 1995). This dissertation explores the processes which bring about structural change, and in so doing constitute therapeutic action. Theory derived from empirical infant research will be used to examine the role of ongoing patterns of self- and mutual regulation in the formation of new expectations and new organising principles – that is new psychic structure. Clinical material drawn from a therapy with an eight-year-old child, will be used to illustrate the process of structure formation.

In line with the current *Zeitgeist*, this dissertation will integrate two domains of knowledge, that of psychoanalytic theory and the findings of empirical infant research. Traditionally psychoanalytic theory has linked three domains: that of development, a model of the mind (psychic structure) and a model of treatment (Lachmann & Beebe, 1992). The findings from infant research have challenged the content of all three domains and the ways in which they have been linked together. A differing perspective on development has brought a different conception of psychic structure and its formation, and consequently of treatment (Lachmann, 2001). With an emphasis on co-construction and interaction, these findings have contributed significantly towards a shift in paradigm to a relational and systems approach to psychoanalytic theory.

The review of the literature examines differing perspectives on the nature of psychic structure and divergent views on the processes of structure formation. It highlights the move away from the concept of psychic structure as an entity, towards a concept of process and pattern of interaction and organisation (Lachmann, 2001). It contrasts the traditional notion that new structure occurs primarily through disruption, frustration and disequilibrium, with the view that structure occurs through a multiplicity of routes. Although the position taken in this dissertation is that new patterns of organisation or psychic structure can occur through a multiplicity of routes, and that in practice this is almost always the case, the clinical material will be used to illustrate one particular principle of structure formation, namely ongoing patterns of self- and mutual regulation. While these various pathways to structural change usually operate together, for heuristic purposes they have been ‘unbundled’. The decision to focus on this particular aspect of structure formation was made, both because it appeared to

be the predominant mutative feature of this therapy and also because the findings of infant research have shed light on the importance of this pathway, which has historically been neglected in favour of theories of disruption and frustration.

One of the most significant contributions from infant research has been to draw attention to the subtle nonverbal aspects of the therapeutic interaction and to explicate these in terms of self- and mutual regulation. This theory provided an invaluable lens through which to view the nonverbal patterns of interaction which emerged during the course of the therapy with a child who was unable to make use of symbolic play and struggled to use words to convey her inner experience. Clinical material will be presented to illustrate the therapist's growing understanding of the nonverbal patterns of interaction and their role in structure formation. The focus will be on the micro-analysis of the patient's and therapist's patterns of self- and mutual regulation and the ways in which each partner affected, and was affected by, the other. An intersubjective approach will be used to understand the workings of this particular dyad and attention will be paid to the impact of both the patient's and the therapist's subjectivity in co-constructing their mutual relatedness.

It is hoped that this dissertation will contribute to the literature on the application of infant research findings to the clinical context and particularly to work with children, as child therapists have been more reticent than their adult counterparts in applying these concepts to their clinical work (Seligman, 1998). There is an attempt to highlight the paradigmatic shift for the therapist which grew out of the clinical experience, and the role of supervision, training, and personal therapy in negotiating this transition. It is hoped that future trainee therapists, who are attempting to learn the theory and practice of psychotherapy, may benefit from this exploration of the processes that effect psychic change, and may begin to hear the unspoken dialogue which can so easily be neglected in the therapeutic exchange.

## 1.1 TERMINOLOGY

1. For the purposes of this dissertation, I have avoided the cumbersome use of his/her, and instead have referred to the therapist as female throughout, unless quoting other sources.
2. The terms analyst and therapist as well as those of psychoanalysis and psychotherapy have distinctly different meanings and implications. However, since I quote from literature that uses these terms variably, it may appear as if I have applied them interchangeably.

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## CHAPTER TWO

### THEORETICAL CONTEXT/ REVIEW OF THE LITERATURE

Exploration of how therapeutic action becomes mutative raises questions about the nature of psychic structure and the processes of psychic structure formation and alteration. The theoretical context for this dissertation will draw from self psychology theory, intersubjectivity theory and the findings of empirical infant research, particularly the work of Frank Lachmann and Beatrice Beebe.

This review of the literature will commence with a brief discussion of the two bodies of knowledge drawn on in this dissertation. This will be followed by an outline of the differing views on the nature of psychic structure from within these perspectives. The third section will consider the contrasting theories on the processes leading to psychic structure formation, within each of these paradigms. The debate will centre on the mechanisms and processes whereby structure formation occurs, whether motivated by frustration, disruption and subsequent repair as suggested in Kohut's original formulations of psychic structure formation; or in the presence of a responsive selfobject relationship as suggested by other self psychologists and intersubjectivists; and primarily as a consequence of ongoing patterns of self- and mutual regulation as hypothesised by Beebe and Lachmann (1994). In the fourth section, Beebe and Lachmann's (1994) proposal that structure formation occurs through a multiplicity of routes will be presented. The principle of ongoing patterns of self and mutual regulation, which they regard as the most pervasive organising principle, will be explored in depth, as it proved the most predominant feature of structure formation in this case study.

The final section of this chapter will consider how the findings of infant research are applicable to psychoanalytic treatment through the principles of interactive regulation, and how through metaphor and analogy, these can shed light on the patterning of patient – therapist interactions. In addition, the manner in which these principles of interactive regulation can illuminate modes of therapeutic action will be discussed. Lastly, the relevance of focusing on patterns of self and mutual regulation in work with patients who struggle to articulate or reflect on their internal experience will be described.

## 2.1 CONTRIBUTIONS FROM TWO BODIES OF KNOWLEDGE

This dissertation integrates two separate domains of knowledge: psychoanalytic theory and the work of infant researchers. Whilst acknowledging the differing methods and assumptions inherent in these two approaches and the difficulty in any direct comparison, “the juxtaposition of psychoanalytic and infant research is in keeping with contemporary psychoanalytic thought which suggests that there is much to be gained by an integrative investigation of the ideas and findings from the two areas” (Zelnick & Buchholz, 1990, p.30). This view is gaining increasing support from developmental theorists, infant researchers and psychoanalytic theorists (Beebe & Lachmann, 1994, 1998; Kiersky & Beebe, 1994; Knoblauch, 1997; Lachmann & Beebe, 1996a, 1996b; Lichtenberg, 1983, 1989; Pally, 2001; Rustin, 1997; Seligman, 1998; Silver, 1983; Silverman, 1992; Soref, 1992; Sorter, 1996; Stechler, 1983; Stern, 1985).

Previously there had been little grounds for collaboration between these two approaches as they produced widely divergent views of the infant and were concerned with different aspects of the infant’s experience. Stern (1985) describes two versions of infancy; the “*observed infant*” (p. 14) derived from meticulous observational studies of infant behaviour at the time of its occurrence and the “*clinical infant*” (p. 14) which is a reconstruction of both the adult patient and the therapist who incorporates theories of infant development and experience. While infant researchers were mainly concerned with non-social aspects of infant development, the opportunity for collaboration was minimal as psychoanalytic theory “has always been concerned with social life as subjectively perceived” (Stern, 1985, p. 14). An integration of these two bodies of knowledge only became possible with the shift of emphasis within infant research towards study of the infant’s lived social experience. Once both approaches began to consider similar questions about the infant, findings which were discordant provided impetus for closer inspection of the hypotheses generated by these two fields. Similarly, areas of overlap and convergence, as can be seen in intersubjectivity theory and systems thinking arising from infant research, have invited comparison and collaboration (Rustin, 1997).

Silver (1983) describes how the approaches of self psychology and infant research inevitably draw together “in that each attempts to evolve a developmental conception of the self, as distinguished from a preoccupation with drives or with the experience-distant concepts of

macrostructures (id., ego, and superego)" (p. 38). To fully understand the development of the self, an integration of the two domains of knowledge is required as "(t)he clinical infant breathes subjective life into the observed infant, while the observed infant points towards the general theories upon which one can build the inferred subjective life of the clinical infant" (Stern, 1985, p. 14).

The debates as to whether the two versions of infancy actually refer to the same subject matter and whether the findings are comparable has been outlined by Stern (1985). While the clinician reconstructing the clinical infant is influenced by the theoretical paradigms within which he or she works, Stern (1985) takes the view that the general hypotheses as to how the mind works exist separately from the many constructed narratives which are influenced by varying theories. He proposes that the observed infant is a source of either supporting or redefining the general hypotheses.

Cohler (as cited in Stechler, 1983) has made attempts to lessen the crib-couch gap, by drawing attention to the wide range of methodological approaches to infant research. While some of the methods involve viewing the infant's behaviour from the outside, others (Beebe & Lachmann, 1992, 1994; Lachmann & Beebe, 1996b; Lichtenberg, 1989; Stern, 1985, 1994; Tronick, 1989) attempt to use a more empathic approach similar to that of the psychoanalytic clinician, and try to infer and hypothesise about the infant's inner life as subjectively perceived. Cohler (as cited in Stechler, 1983) views the relevance of infant research for psychoanalysis and more specifically for self psychology as based "on the specific methodological question of whether the baby watcher is operating as the empathic analyst does and not on whether the subject is a baby or a patient in analysis" (Stechler, 1983, p. 45).

Stechler (1983) suggests that whilst the reconstructive view of infancy differs from the contemporaneous view, both are relevant and a bridge between the two domains would lead to a greater understanding as "scientific advancement comes when we can triangulate on a common problem using a range of methods" (p. 43). The models of development derived from infant research cannot be translated directly into the psychoanalytic situation and cannot be used to prove psychoanalytic theory as "(i)n adults, the capacity for symbolization and the subjective elaboration of experience in the form of fantasies, wishes, and defenses further modifies the organization and representation of interactive patterns" (Lachmann & Beebe, 1996b, p. 124). However, its relevance is that "it makes no assumptions about the dynamic

content of adult experience. It focuses entirely on the process of interactive regulation” (Lachmann & Beebe, 1996a, p. 3).

Psychoanalysts are beginning to integrate the broad base of empirical findings into their theories and to apply these to clinical work with adults and children (Fonagy, 1998; Harrison, 1998; Lachmann & Beebe, 1996a, 1996b; Kiersky & Beebe, 1994; Knoblauch, 1997; Lyons-Ruth, 1998; Rustin, 1997; Sorter, 1996; Stern, 1998). Common to both infant research and adult psychoanalytic theory is the incorporation of a systems view which has led psychoanalytic theorists to consider more closely the role of interaction in the dyad, where previously the emphasis was on the organisation of inner states (Beebe & Lachmann, 1998). Psychoanalysts can utilise the data emerging from infant research to define and refine more specifically the concept of therapeutic action (Rustin, 1997). The contribution from infant research to understanding the dyadic interaction and therapeutic action in this case study will be illustrated in Chapter 5.

## 2.2 THE NATURE OF PSYCHIC STRUCTURE

According to Greenberg and Mitchell (1983) “(a)ll psychoanalytic theories presuppose enduring characteristic patterns and functions that typify the individual personality. Such patterns and functions organise experience and mediate between experience and subsequent behavioural response” (p. 20). These patterns and functions are generally known as ‘psychic structures’ which Rapaport (cited in Lee & Martin, 1991) describes as “configurations with a slow rate of change” (p. 238). Schafer (1988) reviewing a series of papers on psychic structure, describes how Freud’s metapsychological theory with its mechanistic model of the mind as a closed energetic system, placed the concept of psychic structure and structural change at the heart of the psychoanalytic enterprise. Lachmann and Beebe (1992) describe how “Freud’s id-ego-superego partitions as organizers of the mind provided the basis for defining structure in psychoanalytic discourse” (p. 145). Since then, attempts to elucidate the concept of psychic structure within psychoanalytic theory, has provided a focus for ongoing debate. Doctors (1996), suggests that the concept of structure within psychoanalysis is currently in a state of theoretical flux. Schafer (1988) describes a “quiet revolution in psychoanalytic theorizing”(p.301) which has resulted in a revision of the concept of psychic structure from being regarded as “a noun, an entity or an essence” (p.308) towards an understanding of the term “to refer to organizations or patterns of function or action” (p.

301). The work of infant researchers and developmentalists has further contributed to the understanding of psychic structure as the interactive organisation of early patterns of experience, the presymbolic representation of “actions-of-self-in-relation to actions-of-other” (Beebe & Lachmann, 1988a, p. 21).

### **2.2.1 Contrasting views of psychic structure within self psychology and intersubjectivity theory**

From a self psychological perspective the formation or strengthening of psychic structure is inextricably linked to the process of cure. Kohut (1984) made this explicit when he suggested that “psychoanalysis cures by the laying down of psychological structure” (1984, p.98). Kohut emphasised that a discussion of psychic structure within self psychology does not refer to “the structures of a mental apparatus nor to the structures of any of the constituents of a mental apparatus but to the structure of the self” (1984, p. 99). The self is defined by Kohut in its broadest sense as the core of the personality, “the centre of the individual’s psychological universe” (1977, p. 311). “It is not knowable in its essence... and only its introspectively or empathically perceived psychological manifestations are open to us” (Kohut, 1977, p. 311). It is an enduring unit, which is the centre of initiative, the recipient of impressions, and repository of ambitions, ideals, talents and skills. (Kohut, 1977; Wolf, 1988). It is “the locus of relationships and an active agent performing functions that were traditionally ascribed to the ego” (St Clair, 1986, p.149).

Wolf (1988) draws attention to the metaphorical nature of the word ‘self’ to describe “the psychological organisation which gives rise to... self experience” (p. 13) and emphasises that reference to “the self’s structure, components and cohesion is also metaphorical” (Wolf, 1988, p.13). Kohut and Wolf (1978), conceptualise the self as a bipolar structure. From one pole emanates the strivings for power and success which arises out of the mirroring self-object experiences; at the other pole resides the basic idealised goals which arise out of idealising self-object experiences. The intermediate area of basic talents and skills establishes a tension- arc between these two poles. Wolf (1988) suggests that the use of the word structure to describe the ‘self’ relates to its relative stability over time and it’s slow rate of change.

A normal, healthy and well functioning self is referred to as a cohesive self. Loss of self structure, results in varying degrees of ‘fragmentation’ of the self which may manifest

clinically as feelings of emptiness, depression, worthlessness, anxiety or loss of self-esteem (Wolf, 1988). Disorders of the self arise when there is “significant failure to achieve cohesion, vigour, or harmony, or a significant loss of these qualities after they had been tentatively established” (Kohut & Wolf, 1978, p. 414). The healthy self can exist in varying degrees of cohesion and Wolf (1988) suggests that the shifts in experiencing the self as more or less cohesive is to some extent a normal process, not necessarily implying a disorder of the self.

Kohut and Wolf (1978) state that the various components of a healthy and firm self are acquired in early childhood through the interplay with those persons experienced as selfobjects. These selfobjects are persons or objects experienced as part of the self or which are used in the service of the self to perform functions for the self (Kohut, 1971, xiv). According to Wolf, “(t)he self cannot exist as a cohesive structure — that is, cannot generate an experience of well-being — apart from the contextual surrounds of appropriate selfobject experiences” (1988, p. 14). Failure to meet the infant’s selfobject needs within the caretaking environment was believed to result in a deficit in psychic structure (Kohut, 1984; Wolf, 1988). The term deficit was used by Kohut to describe both “functional disabilities as well as the structural organization that accounted for a patient’s functional disabilities” (Lachmann & Beebe, 1992, p. 138). These functional disabilities included difficulties with self-soothing, or an inability to self-regulate affect or arousal. The conflation of these two aspects of psychic structure is considered inappropriate, both by the intersubjectivists and the infant researchers.

Kohut and Wolf (1978) and Wolf (1988) outline two essential selfobject needs for the formation of self structure: the need for a mirroring selfobject which provides confirmation for the child’s innate sense of vigour, greatness and perfection, and the need for an idealised selfobject experience which the child perceives as an image of calmness, infallibility and omnipotence with which s/he can merge. Wolf (1988) describes additional selfobject experiences such as alter-ego (twinship) selfobject experiences which provide experiences of likeness that sustain the self and adversarial selfobject experiences that are needed for the development of healthy assertiveness.

The intersubjectivity theorists are critical of Kohut’s view of psychic structure on the grounds that his conceptualisation of the ‘self’ involves a reification, not dissimilar to the Freudian view of a mental apparatus. Kohut, instead of considering the self “solely as an individual’s

intersubjectively constituted experience of his or her own personhood...viewed (it) as a mental entity in its own right, achieving through processes of (transmuting) internalization varying degrees of its own internal structuralization” (Orange, Atwood, & Stolorow, 1997, p. 64).

Stolorow, Brandschaft, and Atwood (1987) and Stolorow and Atwood (1992) note that Kohut used the concept of the self to refer to **both** an organization of experience, and an independent initiator of action which has the capacity to perform functions for the self. They quote an example of this dual usage: “The fragmented self strives to restore its (own) cohesion” (Stolorow et al., 1987, p. 18). They suggest that the use of the term ‘self’, to refer to an initiator of action should be replaced by the concept of ‘person’ and the use of the term ‘self’ should be reserved for the “psychological structure through which self-experience acquires cohesion and continuity, and by virtue of which self-experience assumes its characteristic shape and enduring organization” (Stolorow et al., 1987, p. 66).

The intersubjectivists consider psychic structure as the “*structure of a person’s experiencing*” (Stolorow & Atwood, 1994, p. 23) and the process of structuralization as the acquisition of “*structures of experience* – the distinctive configurations of self and other that shape and organize a person’s subjective world” (p. 23). Structures are not regarded as simply internalisations, nor as physical structures in a mental apparatus, but rather as “systems of ordering...through which a person’s experience of self and other assume their characteristic forms and meanings” (Stolorow & Atwood, 1994, p. 23-24). These systems of ordering are broad patterns referred to as **organising principles**, which are the central components of subjectivity (Orange et al., 1997). Stolorow and Atwood (1992) suggest that “recurring patterns of intersubjective transaction within the developmental system result in the establishment of invariant principles that unconsciously organize the child’s subsequent experiences” (p. 24). These organising principles “are the emotional conclusions a person has drawn from lifelong experience of the emotional environment, especially the complex mutual connections with early caregivers” (Orange et al., 1997, p. 7).

Organising principles are largely unconscious, operating out of awareness in structuring an individual’s subjective world. Intersubjectivity theory locates these principles in a domain which they term the “prereflective” unconscious (Atwood & Stolorow, 1984, p.42). Stolorow and Atwood (1992) and Stolorow (1994b) emphasise that, from an intersubjective

perspective, successful therapeutic intervention and the formation of new psychic structure does not result from altering or eliminating the existing organising principles. They suggest instead, that through new relational experience with the therapist and the patient's increased capacity for self-reflection, alternative principles for organising experience gradually emerge.

### **2.2.2 The contribution of infant research to the understanding of psychic structure**

There is no unified definition of psychic structure within the empirical infant research literature and the most general understanding of the term is the schemas or patterns which organise infant experience. Stechler and Kaplan (1980) consider structure to be "the development of an increasingly complex set of organising principles that facilitate self regulation" (p. 101). Whilst utilising the concept of structure, they draw attention to the concerns of using "the familiar language of 'structure' and 'structure building'...which lends itself to the possible translation of a process into a solid entity" (Stechler & Kaplan, 1980, p. 101).

Beebe, Lachmann and Jaffe (1997) offer a definition of structure "as relatively persistent patterns and classifications of information, or a model used to organise incoming information" (p. 151). These authors suggest that "these patterns are formed by the active process of constructing or reconstructing incoming information" (Beebe et al., 1997, p.151). When describing the development of psychic structure in infancy, Beebe and Lachmann (1988a; 1988b) regard these patterns as the precursors of psychic structure, as these schemas (structures) undergo change through the development of symbolic capacities and later developmental experience. This view derives from a transformational model of development (Sander, 1983a). The patterns which organise experience are derived from the expectation and representation of early interaction structures (prototypic patterns of self and mutual regulation). These patterns become organised or categorised by means of 3 salient principles (Beebe & Lachmann, 1994).

Central to Lachmann and Beebe's (1992) view of structure formation is that mutual regulatory and self-regulatory processes provide the most basic and pervasive organization of experience. The major contribution of empirical infant research has been to elaborate on the interactional nature of psychic structure formation (Beebe & Lachmann, 1988a, 1988b, 1992, 1994; Demos, 1983; Emde, 1983, 1988a, 1988b; Lachmann & Beebe, 1996a, 1996b; Sander, 1977, 1983a, 1983b, 1987; Stechler & Kaplan, 1980; Stern, 1983, 1985, 1989, 1994, 1998;

Tronick, 1989; Tronick & Cohn, 1989). The infant possesses innate capacities which enables it to represent the interaction structures presymbolically. These presymbolic representational capacities will be discussed more fully in section 2.3.3.

What is represented in purely social exchanges is the dynamic interactive process itself, that is "actions-of-self-in-relation-to-actions-of-objects" (Beebe & Lachmann, 1992, p. 106; Beebe & Lachmann, 1994). Towards the end of the first year the infant's representations of expected interaction structures are abstracted into generalised prototypes. These prototypes become the basis for self and object representations after the first year (Beebe et al., 1997). Zelnick and Buchholz (1990) suggest that these early interaction structures at the presymbolic level will later constitute largely unconscious organising structures. This is supported by Lachmann and Beebe (1992) who believe that unconscious organizing principles, described by the intersubjectivists, can be viewed as later transformations of earlier interaction structures.

### **2.3 THE PROCESS OF PSYCHIC STRUCTURE FORMATION**

There are two central debates in the literature on the processes leading to the formation of psychic structure. The first debate focuses on the relative importance of intrapsychic versus relational factors in the process of structure formation.

Traditionally, psychoanalytic theory has tended to focus on a model of psychic structure formation in which the intrapsychic organization of experience is primary. "Experience is shaped initially according to one's needs, one's biologically based urges, and, later, by wishes, although certainly the environment plays a role" (Beebe, Jaffe & Lachmann, 1992, p. 74). This theoretical model has been regarded as a 'one-person model' (Fosshage, 1992). In contrast to this, numerous psychoanalytic theorists, beginning with Fairbairn and developing into the object relations school, placed a greater emphasis on the contribution of the environment and significant relationships in the formation of psychic structure and on the interactive nature of psychoanalysis (Grotstein & Rinsley, 1994). This model became known as a 'two-person model' (Fosshage, 1992).

Greenberg and Mitchell (1983) describe the polarities and contrasts between these two models, which were historically regarded as almost mutually exclusive. More recently, with

the impact of systems thinking on psychoanalytic theory there has been an even greater move within psychoanalysis towards “seeking a theory of interaction” (Beebe & Lachmann, 1998, p. 480). These theories, including Stolorow, Brandchaft and Atwood’s (1987) intersubjectivity theory, Mitchell’s (1988) relational theory and Beebe, Jaffe and Lachmann’s (1992) dyadic systems model have all emphasised the role of dyadic interaction in psychic structure formation.

Similarly, within the field of infant research, debates have focussed on the primacy of self- or mutual regulation in the formation of psychic structure. Previously, there was a preoccupation with interactive regulation, and only more recently has self- regulation been the focus of inquiry (Beebe & Lachmann, 1998). Coming from a history of contrasting bias, psychoanalysis and infant research have both moved towards an integration of the influences of intrapsychic and relational, self- and mutual regulation on the development of psychic structure. This dissertation will not pursue the debates around these divergent positions in detail, but will highlight the current emphasis on an integration of these two perspectives.

The second debate, which is explored more fully in this dissertation, is whether the process is motivated by frustration and disruption and its subsequent repair; or whether positive relational experiences, optimal responsiveness and ongoing patterns of self- and mutual regulation, are equally significant pathways to structure formation.

### **2.3.1 The process of structure formation within self psychology :**

#### **frustration vs responsiveness**

Since Kohut’s (1971, 1977, 1984) focus on the role of optimal frustration in structure formation, there has been ongoing debate within self psychology and intersubjectivity theory as to the importance of frustration as the central factor in the process of structure formation.

Kohut introduced the concept of optimal frustration when he was still theorising and practicing within classical drive theory. He described optimal frustration as occurring in response to selfobject failures which are tolerable and which are not of sufficient degree to be regarded as traumatic frustrations. Kohut believed that optimal frustration of instinctual impulses promoted the development of internal psychic structure, composed of transformed or sublimated instinctual drives (Bacal, 1985). In *The Analysis of the Self*, Kohut (1971) still working within a classical framework emphasised the importance of optimal frustration, not for drive modification, but for the achievement of narcissistic equilibrium.

In The Restoration of the Self (1977), he continued to highlight the centrality of optimal frustration in the process of transmuting internalization by means of which aspects of the selfobject, in the form of specific functions, are taken in by the child and form inner structures.

Little by little as a result of innumerable processes of microinternalization, the anxiety-assuaging, delay-tolerating, and other realistic aspects of the analyst's image become part of the analysand's psychological equipment, *pari-passu* with the micro-frustration of the analysand's need for the analyst's permanent presence and perfect functioning in this respect. In brief, through the process of transmuting internalization [via optimal frustration] new psychological structure is built.

(Kohut, 1977, p. 32)

In his last work, How Does Analysis Cure? (1984) Kohut had moved away from his overt ties to classical drive theory, but retained his belief in the centrality of frustration for the development of new self structure. Kohut viewed transmuting internalization as a three step sequence of "(1) need-activation and optimal frustration via (2) nonfulfillment of the need ('abstinence') and (3) substitution of direct need fulfillment with the establishment of a bond of empathy between self and selfobject..." (1984, p. 103). He suggested that countless repetitions of basic attunement and optimal frustration over the course of treatment result in the internalization of impersonal functions associated with the selfobject analyst.

A number of theorists within self psychology (Bacal, 1985, 1988; Bacal & Newman, 1990; Lindon, 1994; Socarides & Stolorow, 1984/85; Shane & Shane, 1996; Terman, 1988) have been critical of the concept of optimal frustration as the central mechanism leading to structure formation. They have posited various alternative ideas which they believe more accurately reflects how the process of structure formation and therefore cure is effected. Bacal (1985) questioned Kohut's assertion that it was optimal frustration via transmuting internalization which resulted in the structuring and restructuring of the self. Bacal (1985) agreed that clinical improvement followed frustrations and their repair, but disputed Kohut's conclusion that the frustration itself played a causative role in structure building. Bacal (1985) argued that new structures arose out of the patient's sense of being understood following the disruptions or frustration and their subsequent repair, "not because the understanding of disruption is therapeutic, but because *understanding* is therapeutic" (p.211). Bacal (1985) introduced the concept of optimal responsiveness in preference to optimal

frustration, defining responsiveness as “the responsivity of the analyst that is therapeutically most relevant at any particular moment in the context of a particular patient and his illness...(it) refers to the therapist’s acts of communicating his understanding to his patient” (Bacal, 1985, p. 202).

Through his concept of optimal responsiveness, Bacal has attempted to “account for healthy structure building in the realm of constructive experiences...(u)nderstanding may be communicated in words or actions, for *all* lived experience is the raw material of structure” (Doctors, 1996, p. 56). Bacal (1985) states “we cannot assume that all internalizing processes occur through frustration. In a good-enough situation, for example, identification and assimilation occur” (p. 225).

Terman (1988) also challenged Kohut’s insistence that optimal frustration is essential for the process of structure formation, which he defined as “the acquisition of pattern and meaning” (p. 114). Terman suggested that “changes in (his) patients occurred because of an understanding of the old and a creation of the new that arose from the experience in the analysis that had nothing to do with frustration...(i)t was the satisfaction of the needs that opened new paths and remade old ones” (1988, p. 114). He believed that whilst frustration may play some role in the formation of patterns or structure, emphasis on frustration led to neglect of the numerous and significant interactions both in the clinical and the developmental situation which create patterns, which through their repetition, lead to structure. Drawing on evidence from developmental studies, Terman argued that “(t)he changing and growth of patterns occur in the context of intense interaction. The *interaction*, not the spaces between the interactions, changes and structures. It is not the *loss* of the transaction, but rather its *presence* that structures” (1988, p. 117).

Terman (1988) shifts the focus from internalization of structure to creation of structure and suggests that the formation of structure is not a two-part process whereby an interaction happens which is then separately transposed inside. He suggests that the experience between mother and child or therapist and patient, the “dialogue of construction” is the structure and occurs as the interaction unfolds – “the doing is the making” (1988, p. 125).

Basch (1995), and Lindon (1994) question the value of abstinence or frustration in facilitating the accretion of psychic structure. Lindon (1994) proposes the concept of optimal provision

in preference to frustration or non-gratification, defining optimal provision as "...any provision that, by meeting a mobilized developmental longing, facilitates the uncovering, illuminating, and transforming of the subjective experiences of the patient" (1994, p. 559). Like Bacal (1985), Lindon believes that the patient's need to feel understood is paramount in treatment and satisfying this need provides the opportunity to create a new experience with a patient.

### **2.3.2 The intersubjectivists' view on structure formation**

Stolorow et al., (1987) believe that Kohut's concept of transmuting internalisation combines two developmental processes which should be considered separately. These two processes include "the patient's gradual acquisition of *functional capacities*" and "the *structuralisation of self-experience*" (1987, p. 23). They criticise Kohut's use of the concept of internalisation to describe the acquisition of these functional capacities, and suggest that to call this process internalisation "introduces misleading physicalistic and spatial reifications...(where) the development of self-regulatory capacities may be more adequately conceptualized in nonspatial terms" (Stolorow et al., 1987, p.23).

Socarides and Stolorow (1984/85) suggest that the therapeutic benefits of analysing disruptions in the selfobject tie with the analyst lies not in the disruption, but in the integration of affect states that these ruptures produce and in the "mending of the broken selfobject tie which, *when intact*, provides a nexus of archaic relatedness in which the patient's derailed emotional growth and the corresponding structuralizations of the self can resume once again..." (p. 112). This process need not include internalisation and does not require the optimal frustration central to Kohut's thesis.

### **2.3.3 The process of psychic structure formation from the perspective of infant research**

The increasing body of empirical infant research into mother-infant interaction in the first months of life has made use of advanced technology such as video monitoring, split screen photography and computer analysis with time series regression, to record the behaviours of each partner in the dyad on a moment to moment basis (Stern, 1984; Beebe & Lachmann, 1988a, 1988b; Brazelton, Koslowski & Main, 1974).

Findings from this research have produced a view of the infant, which is substantially different to that traditionally postulated by various psychoanalytic theorists (Emde, 1988a; Horner, 1985; Lichtenberg, 1989; Stern, 1985). Contrary to traditionally held views,

the neonate is not *tabula rasa*, nor undifferentiated, nor passive, nor initially unrelated to the environment. The infant cannot be described as spending the better part of his or her day struggling with infantile rage or paranoid dangers or escaping from primary anxiety. Most important, especially with respect to very early development, the **full** range of capacities at birth with which infants engage their human and nonhuman environment has not been appreciated.

(Lachmann & Beebe, 1992, p. 139)

Stern (1983, 1985) has made a major contribution in challenging the assumptions inherent in the traditionally held views of infancy and of development. He proposed that the infant is not undifferentiated from the mother at birth and does not move from a position of merger to a state of separateness. By the first half of the first year the infant has the capacity to form distinct schema's of self, other and self-with-other. In addition he believed that the traditional view of development as proceeding in a linear fashion through different stages, each preoccupied with the resolution of particular clinical issues such as orality, trust, symbiosis and autonomy (depending on the theoretical perspective) is not supported by the observation of infants. He suggests that infant observers recognise phases of development, not linked to later clinical issues, but seen "rather in terms of current adaptive tasks that arise because of maturation of the infant's physical and mental capacities....a progression of developmental issues that the dyad must negotiate together for adaptation to proceed" (Stern, 1985, p. 24).

The findings from infant research suggest that from the beginning of life the infant has a wide range of early cognitive, social and perceptual capacities with which to engage with its caretaker in an active construction of its internal and interpersonal world (Lewis & Rosenblum, 1974; Lichtenberg, 1983). The infant is viewed as active, perceptually competent and stimulus-seeking from the earliest days of life (Zelnick & Buchholz, 1990).

Psychoanalytic theorists, writing from diverse theoretical perspectives have regarded interaction as central to the process of psychic structure formation and the representation of self and object (Mitchell, 1988; Orange et al., 1997; Stolorow et al., 1987; Terman, 1988). A

number of infant researchers have provided support for this position in emphasising the centrality of dyadic interaction in the process of psychic structure formation (Beebe & Lachmann, 1988a, 1988b, 1992, 1994; Demos, 1983; Emde, 1983, 1988a, 1988b; Lachmann & Beebe 1996a, 1996b; Sander, 1977, 1983a, 1983b, 1987; Stehler & Kaplan, 1980; Stern, 1983, 1985, 1989, 1994, 1998; Tronick, 1989; Tronick & Cohn, 1989; Zeanah, Anders, Seifer & Stern, 1989).

Infant researchers have been able to illuminate the detailed workings of this dyadic interaction by close empirical scrutiny of the caregiver-infant dyad. Their pivotal contribution has been to elaborate on **how** these internal models of self, object and self-with-object evolve out of patterns of interaction. Firstly, with the use of innovative technology, they have been able to document, in minute detail, a variety of patterns of interactive regulation (Beebe & Lachmann, 1988a, 1988b, 1992; Beebe et al., 1997; Brazelton et al., 1974; Sander, 1977, 1983a, 1983b; Stern 1983, 1985; Tronick, 1989; Tronick & Cohn, 1989). Secondly, they have been able to produce evidence for a pre-symbolic representational capacity (Beebe & Lachmann, 1988b; Zelnick & Buchholz, 1990). Together these findings made it possible to suggest ways in which patterns of interactive regulation become represented and ultimately transformed into psychic structure.

Interaction structures provide an important basis for the organisation of infant experience, and can be viewed as “characteristic patterns of the ways mother and infant influence each other, patterns of the ways the interaction unfolds” (Beebe et al., 1997, p.135). Different researchers have focussed on the primacy of either self or mutual regulation within the dyad as the central organising feature of psychic structure formation. Beebe and Lachmann (1994) suggest that interaction structures include both self and mutual regulation. They propose that interaction structures, are represented in a presymbolic form in the first months of life. They believe that it is these presymbolic representations which provide the foundations for the emergence of later, symbolic, forms of self- and object representations.

Historically, representational and pre-representational processes were regarded as distinct, with representational capacities viewed as a developmental achievement, occurring with symbolic thought (Emde, 1983). Studies of infant perception and memory suggest that a rudimentary and general representational ability exists as early as the first months of life (Beebe & Lachmann, 1992), what Lichtenberg (1989) terms “perceptual-affective-action

patterns" (p. 3). Beebe and Lachmann, (1988b, 1992) detail the evidence for the existence of these early presymbolic representational capacities which include the ability to perceive distinctive features, to translate cross-modally, to detect whether the behaviour of a partner is contingent or not and to recognise familiar or unfamiliar behaviour patterns (Beebe & Lachmann, 1988b, 1992; Beebe et al., 1997). This early representational capacity has been defined as the "storage of distinctive features of stimuli" (Beebe & Lachmann, 1992, p. 86).

The infant will represent specific features of the dyadic interaction, including, the temporal patterning of the behaviour of the partners, the presence or absence of mutual influence, the movement of the two partners in space and the facial affective pattern (Beebe & Lachmann, 1992; Beebe et al., 1997). A schema is constructed of the expected moment-to-moment interchange between the two partners (Beebe & Lachmann, 1994). The repetition of these interactive patterns leads to expectancies of how interactions will typically proceed (Beebe & Lachmann, 1988a). These expectancies of social interactions are organised through time, space, affect and arousal. The infant's capacity to generate expectancies and to detect contingencies between their behaviours and the response of the environment is central to their ability to represent these interactive patterns of both self- and mutual regulation (Beebe & Lachmann, 1992; Rustin, 1997). Towards the end of the first year when the capacity for abstraction develops, the expectancies of characteristic interaction structures become generalised prototypes, which form the basis for later forms of symbolic representation (Beebe & Lachmann, 1992; Beebe et al., 1997). This is analogous to the argument put forward by Stern (1985) in which representations of interactions become generalised (RIGs).

There are differing viewpoints within the infant research findings and literature (which parallel the debates within self psychology and intersubjectivity theory) as to what aspects of dyadic interaction take primacy in organising infant experience. The early findings of infant researchers, writing from widely divergent vantage points, broadly supported one of two viewpoints. Both views posit that "structure is acquired when a set of organizing principles become represented as the predictable 'rules' of the relationship" (Beebe & Lachmann, 1988a, p. 20). The first model emphasises the role of characteristic, predictable patterns of interactive regulation, which organise the infants' experience (Beebe & Lachmann, 1988a, 1988b, 1992; Emde, 1983; Sander, 1977, 1983a; Stern, 1983, 1985). This view is consonant with the position of post Kohut self psychologists such as Bacal (1985, 1988) Terman (1988) and Lindon (1994) who suggest that structure arises out of interaction and not in its absence;

and that positive, repeated interactions create new patterns and new expectations of being understood. According to the second model, psychic structure accrues through efforts to resolve disruptions or violations of expectancy in the interaction between caregiver and infant (Beebe & Lachmann, 1994; Behrends & Blatt, 1985; Gianino & Tronick, 1988; Horner, 1985; Lachmann & Beebe, 1996a; Stechler & Kaplan, 1980; Tronick, 1989; Tronick & Cohn, 1989). The idea that psychic structure is formed through the dyads' attempts to resolve violations of expectancy is similar to Kohut's emphasis on optimal non-traumatic frustration leading to the development of psychic structure through transmuting internalization.

#### 2.4 SALIENT PRINCIPLES IN STRUCTURE FORMATION

Beebe and Lachmann (1994) and Lachmann and Beebe (1996a, 1996b) have reviewed thirty years of research on the organisation of infant experience from which they have generated hypotheses to describe how social interactions between infant and caregiver become patterned and salient in the first year. In contrast to Kohut's theory that internalisation results from optimal frustration alone, they propose that internalisation occurs through a multiplicity of routes (Mitchell & Black, 1995, p. 167). The two views of structure formation, described above, constitute their first two principles of organisation: **ongoing regulations** and **disruption and repair** of ongoing regulations. A third principle of organisation, '**heightened affective moments**' was later added. Beebe and Lachmann (1994) suggest that there could be additional salient principles which have yet to be elucidated. These three principles describe the key features of different patterns of dyadic regulation and also serve as criteria which enable the infant to recognise these familiar patterns and to categorise and presymbolically represent them. Each principle will generate particular expectancies of how social interactions will proceed.

Beebe and Lachmann (1994) emphasise that all three principles usually operate together, and all may play a role in the construction of expectancies. In any particular situation "one may be more compelling than the others" (Beebe & Lachmann, 1994). As this case study highlights the role of ongoing self- and mutual regulation, this principle will be the focus of this section. The principle of disruption and repair will also be considered, inasmuch as Beebe and Lachmann (1994), in retaining this principle, provide an alternative view of how disruption and repair contribute to the formation of psychic structure.

### 2.4.1 Ongoing self- and mutual regulation

According to the principle of ongoing regulations, interaction structures (prototypic patterns of dyadic regulation) are recurrent, characteristic patterns of self- and mutual regulation, which the infant comes to expect and represent (Beebe & Lachmann, 1994). Whilst disruptions and efforts to resolve these disruptions were regarded as the necessary precondition for structure formation, expectancies created by ongoing patterns of interaction are an equal or perhaps more powerfully organising feature of experience.

Self-regulation refers to the capacity of an individual to manage his or her own states of arousal and affect, to self-comfort and to maintain an inner state of equilibrium (Lachmann & Beebe, 1996a). In infants, the ability to self-regulate is influenced by innate and temperamental factors, and differences in self-regulatory styles affect the success of mutual regulation. Equally, the nature of interactive regulation can facilitate or impair self-regulatory capacities (Tronick, 1989; Lachmann & Beebe, 1996b).

Beebe and Lachmann (1992, 1994, 1998) and Lachmann and Beebe (1996a, 1996b) define mutual regulation as the process in which each partner in a dyad contributes to the structure of the exchange, although not necessarily in an equal or symmetrical manner. The behaviour of each partner influences that of the other on an ongoing basis, so that it becomes possible to predict the behaviour of one partner from that of the other. Previously, emphasis was placed on the parents' influence on the child, or the child's influence on the parent, without consideration of the **interactive** effect of each on the other partner (Gianino & Tronick, 1988; Lewis & Rosenblum, 1974). It is now well recognised that interactions between mother and infant are shaped by patterns of mutual influence and that each partner actively contributes to the regulation of the exchange. Patterns of interactive regulation between caretaker and infant have been documented across various modalities such as gaze, vocalization, timing and general affective involvement (Beebe & Lachmann, 1988a, 1988b, 1992; Stern, 1974, 1985). Mutually regulated interactions may be positive or successful with patterns of matching, or may be less successful, disrupted or aversive with interactions of derailment (Beebe & Lachmann, 1988a, 1998).

The introduction by Sander (1977, 1983a, 1983b, 1987) of a systems view to the study of mother-infant interaction, led to the appreciation of a regulatory systems perspective in which the organisation of behaviour and experience is seen as an emergent dyadic phenomenon, a

property of the infant-caregiver system as well as a property of the individual. This dyadic systems view, integrates the simultaneous influences of self- and mutual regulation and suggests that to understand the interaction, one needs to consider how each partner is simultaneously affected by his or her own behaviour as well as that of the partner (Beebe & Lachmann, 1998).

The integration of self- and mutual regulation was illustrated in the works of both Sander (1977, 1983b) and Tronick (1989). Sander's (1977) studies on the infant's capacity to establish a sleep-wake cycle in the first weeks of life, demonstrated that this self-regulatory capacity was dependent on the mutual regulation within the caregiver-infant system. His studies indicated that infants roomed in with their mothers, or those awaiting fostering who had a regular caregiver assigned to them, where adequate mutual regulation was present, were able to establish a regular sleep-wake cycle. Those who were cared for according to a pre-set schedule in a hospital nursery, with multiple caregivers where caretaking was not mutually regulated, were unable to establish day-night differentiation. Sander suggests that "regulation which is based on individual differences of both infant and caretaker is highly specific for them and leads to the unique and idiosyncratic characteristics of exchange in the natural mother system" (1977, p. 146).

Tronick (1989) and Gianino and Tronick (1988) utilise evidence from the "still-face" experiment to propose that self-regulation and interactive regulation occur simultaneously and are highly correlated. In the experiment which exposes the infant to interactive stress, the mother maintains eye contact with the infant, but is asked to remain expressionless and unresponsive. They found that the infants who demonstrated better self-regulatory abilities and attempted to continue engaging with the mother, were those who had better mutual regulation in interactive play. In contrast, those infants with evidence of poor mutual regulation, were not able to continue to engage with the mother and turned to strategies of self-comfort or withdrawal. The recognition that self- and mutual regulation are simultaneous and reciprocal processes, each impacting on the other, provides the basis for the conclusion that "...dyadic process may (re-) organize both inner and relational processes, and reciprocally, changes in self-regulation in either partner may alter the interactive process" (Beebe & Lachmann, 1998, p.481).

The principle of ongoing regulations refers to those “characteristic, predictable, and expected ways in which an interaction unfolds” (Beebe & Lachmann, 1994, p.132). These repeated patterns lead to the construction of a shared set of ‘rules’ which allows each partner to develop an expectation of how an interaction will proceed and to anticipate the actions of the partner (Beebe & Lachmann, 1992). Each partner represents aspects of the mutually regulated interaction (actions-of-self in relation to actions- of-other) **as well as the associated self-regulatory process**. Both partners develop expectations of being affected by and being able to affect each other in particular ways (Tronick, 1989).

Ongoing patterns of self- and mutual regulation are organised by means of time, space, affect and arousal. It is these features of the prototypic patterns of regulation (interaction structures) which the infant will represent. These patterns of interactive regulation were investigated in a series of experiments evaluating the direction of influence in the dyadic interaction and exploring the ways in which the engagement between the two partners becomes organised (Beebe et al., 1997). Beebe and Lachmann (1988b) suggest that “all the patterns provide different ways in which each partner enters the other’s state and affects and is affected by the other’s state. From these patterns, various different nuances of the infant’s ‘experience’ of being with the mother can be inferred” (p. 315). While inferences about the infant’s experience may be useful in understanding how these interaction structures become transformed into unique organising principles, the process is not without difficulties (Beebe and Lachmann, 1988a, 1988b; Stern, 1985). Beebe and Lachmann state that

The translation of the findings of the regulation of action patterns into the language of experience always involves considerable inference and is difficult at best. Whereas psychoanalysis emphasizes how self and object are experienced, mother-infant interaction research measures what the two partners do. In making inferences from behaviour to experience, it is assumed that at this age (in the first six months) the infant’s action closely parallel his experience. In later development, action and experience can be increasingly dissociated and even contradictory. But the infant cannot hide his distress, pleasure, or fatigue.

(Beebe & Lachmann, 1992, p. 98)

In their writings Beebe and Lachmann (1988a, 1988b, 1992) detail the various experiments on facial mirroring, interpersonal timing and derailment (for a full review see Beebe et al., 1997). All the studies used slightly different methodology depending on the dimension (affect, arousal, timing etc.) which was being investigated, but they all recorded the behaviours of

both partners in the dyad and made use of the time-series regression technique described in the experiment below. It is beyond the scope of this dissertation to review these findings in any detail, but brief examples of some of these interaction structures will be presented, along with the inferences about the implications of these patterns for the organisation of the infant's experience.

#### 2.4.1.1 Optimal ongoing regulations of facial mirroring

In the experiments on facial mirroring, mothers were asked to engage in face-to-face social play with their three- to four-month-old infants, as at this age there is a burgeoning of the infant's social capacities (Lachmann & Beebe, 1992). Two video cameras trained on both mother and infant produced a split-screen view of the interaction which, when slowed down and analysed frame by frame, made it possible to view subtle interactions not visible to the naked eye (Beebe & Lachmann, 1988b). In order to analyse the moment-to-moment interaction, a scale was developed to quantify and document the infant's levels of orientation, visual attention and facial expressiveness in relation to the mother (Beebe & Lachmann, 1992). "It is a scale of increasing and decreasing affective 'engagement'. The scale quantifies a continuum from high positive engagement, through a midpoint of looking with neutral face at the partner, to a low point of a limp, motionless, nonreactive state" (Beebe & Lachmann, 1988a, p. 9). A similar scale was developed to chart maternal responses. Findings were analysed using time-series regression in an attempt to discern patterns of influence.

These studies found that mother and infant inhabit a split second world of responsivity, each influencing and being influenced by the other through micro-adjustments lasting approximately one-third to one-half second (Beebe & Lachmann, 1988b). In studies on facial mirroring it was found that mothers and infants do not match the exact level of engagement, but rather match the increasing or decreasing direction of engagement change (Beebe & Lachmann, 1988a). Each partner matches the direction that the other is moving towards and is acutely sensitive to affective engagement changes in the partner (Beebe & Lachmann, 1988b). The time-series regression analysis indicated that matching is mutually regulated and that both mother and infant influence each other to "follow or track the direction of affective engagement change on a moment to moment basis" (Beebe & Lachmann, 1992, p. 95).

Beebe et al. (1997) believe that to the extent that facial mirroring interactions are positively correlated, with both partners moving in the same affective direction and sensitive to changes

in the partners direction, the infant will represent the expectation of matching and being matched. The experiences of matching within the dyad “will provide each (with) a behavioural basis for knowing and entering into the partner’s perception, temporal world, and feeling state” (Beebe & Lachmann, 1992, p. 99). They suggest that once symbol formation develops, these experiences of affective matching may contribute to an expectation of being attuned to, esteemed of, or known. Stern (1984) makes a similar argument about the effect of maternal attunement on the infant’s capacity to experience inner states as shareable with another, suggesting that “the specific segments of the subjective world of feeling that are attuned to will be considered shareable and become the stuff of intimacy” (p. 12). Stern (1985) prefers the concept of affect attunement to that of matching, as he believes that the concept of affect attunement accounts for the behaviours in which caregivers match the intensity of the infant’s affect across various modalities. An example of this would be the adult’s physical expression of excitement such as hunching the shoulders, widening the eyes and opening the mouth, in response the infant’s exuberant ‘aaaah’. These experiences may also lead to expectations of efficacy and agency as the infant expects to elicit the desired response from the partner and to be able to impact on the partner (Rustin, 1997). The studies on facial mirroring which illustrate a matching of affective direction are an example of an optimal ongoing regulation.

#### 2.4.1.2 Misregulated ongoing regulations in the spatial dimension

In studies on the organization of the interaction along spatial lines, an example of a misregulated ongoing regulation, termed derailment or “chase and dodge” was described (Beebe & Stern, 1977 as cited in Stern, 1985). In this interaction which illustrates maternal overstimulation and infant withdrawal, the mother loomed in towards the infant and the infant attempted to escape the maternal intrusion by turning away and averting it’s gaze.

The mother ‘chased’ by following the infant’s head and body movements with her own head and body, pulling his arm, picking him up to readjust his orientation, or attempting to force his head in her direction. The infant ‘dodged’ by moving back, ducking his head down, turning away, pulling his hand from her grasp, or becoming limp and unresponsive

(Beebe & Lachmann, 1992, p. 102).

The interaction, although non-optimal, was still mutually regulated, as each partner continues to influence the other on an ongoing basis. Maternal ‘chasing’ influences the infant to ‘dodge’ and increased withdrawal of the infant, increases maternal chasing. This pattern is

non-optimal in that the infant's attempts at self-regulation such as averting gaze and shifting position away from the mother, do not have the mutually regulating effect of decreasing the mother's stimulation (Beebe & Lachmann, 1994). Instead the dyad is misattuned and expectancies of misregulation of spatial-orientation patterns organise the infant's experience. In addition, the infant is unable to rely on mutual regulation to aid in the self-regulation of attention, affect and arousal (Beebe & Lachmann, 1988b).

Ongoing regulations in the temporal dimension have also been illustrated in studies on varying aspects of interpersonal timing. The findings from research which assessed the relationship between vocal rhythm co-ordination at four months and infant attachment at twelve months (as measured by Ainsworth's strange situation procedure) illustrated that mother and infant are extremely sensitive to each other's vocal rhythms, co-ordinating their own rhythms in response to variations in the partner (Beebe, Jaffe, Lachmann, Feldstein, Crown & Jasnow, 2000).

The findings from this research have led to further insights into the mutual regulation model of interaction in relation to attachment (Beebe et al., 2000). In the original formulations (Beebe & Lachmann, 1988a, 1988b, 1992) it was postulated that the very presence of mutual regulation was "the hallmark of an optimal developmental process" (Beebe et al., 2000, p. 111). The findings arising out of studies of vocal rhythm co-ordination and consequent attachment patterns, suggest that it is not simply enough to know that there is evidence of mutual regulation, the nature and extent of the mutual regulation is critical to predicting the subsequent attachment pattern. Beebe et al. (2000) found that the highest degrees of mutual regulation evidenced in high vocal rhythm co-ordination, were predictive of anxious-resistant and disorganised attachment patterns. Insufficient mutual regulation, evidenced in extremely low vocal rhythm co-ordination was predictive of insecure-avoidant infants. The most securely attached infants were those where vocal co-ordination and mutual regulation was in the mid-range. Beebe et al. (1997), and Beebe et al. (2000) suggest that a balance between self and mutual regulation is necessary for optimal development in which "interactive coupling is present but not obligatory and self-regulation is preserved but not excessive" (Beebe & Lachmann, 1998, p. 485).

Tronick (1989), Beebe and Lachmann (1998) and Beebe et al. (2000) outline a "systems model of pathology as a relative balance between simultaneous interactive regulation and self

regulation” (Beebe et al., 2000, p. 111). In a system that is operating optimally there is flexibility to move back and forth between self- and mutual regulation. Beebe and Lachmann (1998) view pathology as an imbalance between self- and mutual regulation in the system, where there is either an excessive monitoring of the partner (mutual regulation) at the expense of self regulation, termed “interactive vigilance” (p. 485) or where there is a preoccupation with self regulation, at the expense of mutual regulation, termed “withdrawal or inhibition” (p. 485).

#### 2.4.2 Disruption and repair of ongoing regulations

While the principle of ongoing regulations emphasises what is expectable, characteristic and predictable in the interaction, the principle of disruption and repair is organised by violations of expectancy and attempts to repair these by both partners. A number of authors have used this model to explain the organisation of representations and the development of psychic structure (Beebe & Lachmann, 1994; Behrends & Blatt, 1985; Gianino & Tronick, 1988; Horner, 1985; Stechler & Kaplan, 1980; Tronick, 1989; Tronick & Cohn, 1989). Beebe and Lachmann (1994) draw attention to the fact that the principle of disruption and repair of ongoing regulations covers a broad range of phenomena from relatively normal mismatched states in the dyad, which they term disjunctions and which may not involve violations of expectancy, to actual violations of expectancy. Stern’s (1984) work on affect attunement in the mother-infant dyad illustrated that “misattunements (intentional and unintentional) influence the infant. They usually result in some alteration or interruption of ongoing infant behavior” (p. 8). Stern’s (1984) study showed that the infant is not only aware of the disruption of an ongoing sequence, but is also aware of its subsequent repair.

As previously described, Kohut’s view of structure formation, in line with much classical psychoanalytic thinking, regarded optimal frustration as a necessary precondition for the development of psychic structure. The concepts of deprivation, frustration, loss and disruption have been viewed as essential to the process of structure formation and have been assumed to “underlie the disruption and repair model of psychic structure formation” (Beebe & Lachmann, 1994, p. 146). Behrends and Blatt (1985) believe that “disruptions of the mother-infant relationship not only are *inevitable*, they are *required* as a necessary precondition for all psychological development” (p. 16). They suggest that without disruption or incompatibility there would be no motivation for the infant to convert the affective tie with the object to internal structure. In their view, internalisation can only occur as a result of disruption

(Behrends & Blatt, 1985). Stechler and Kaplan (1980) agree that it is through breaches of expectancy, discontinuities, incompatibilities and innumerable attempts to resolve these crises that the development of self-regulating functions occurs.

Beebe and Lachmann (1994) provide an alternative perspective on disruption and repair. They emphasise that in their use of a model of disruption and repair they “do not assume a deprivation model of motivation”(p. 146) but instead “assume an information-processing model in which the infant’s perceptual abilities ensure a capacity for seeking out, perceiving and interacting with social partners” (p.146). The organising impact of disruption and repair of ongoing regulations resides in the creation of expectancies of disruption and repair, or lack of repair, and the ensuing representations for the infant.

The principle of disruption and repair can be illustrated through studies on match-mismatch in the dyad (Tronick & Cohn, 1989) and are best operationalised through experimental studies on disruption and repair using the still-face experiment (Gianino & Tronick, 1988; Tronick, 1989). Tronick and Cohn’s (1989) data on match-mismatch in mother-infant face-to-face interaction illustrated that mothers and infants do not necessarily achieve a constant match in their interactions and shifted continuously between matched and mismatched states. Brazelton et al. (1974) also noted periods of disengagement in the mother-infant dyad. Miscoordinated states are referred to as “interactive error, and the transition from a miscoordinated state to a coordinated state as a process of repair” (Tronick & Cohn, 1989, p. 90). The frequency of repair ranged from once every 3 to 5 seconds, indicating that repair was a recurring feature of infant-mother face-to-face interaction. In addition, it was demonstrated that both partners actively contribute to the repair sequence, which is therefore a mutually regulated achievement. The capacity to participate in repair is a central feature of infant development, enabling the infant to increase its interactive skills, develop a sense of effectance, foster self-regulatory skills which facilitate coping with more extreme forms of interactive stress (Gianino & Tronick, 1988; Tronick, 1989; Tronick & Cohn, 1989). Interactions are represented as reparable and confirm the infant’s expectancy of its own ability to participate in successful repair (Beebe & Lachmann, 1994).

The still-face experiment studies the infant’s ability to deal with a violation of social expectancy (Gianino & Tronick, 1988; Tronick, 1989). In this experiment the mother is asked to present the infant with a still, unsmiling face. The findings illustrate that initially the infant

attempts to repair the interaction by smiling at the mother. After a number of failed attempts to elicit the mother's response the infant withdraws as if giving up, and averts its head and body from the mother and loses postural control. Gianino and Tronick (1988) conclude that extreme stress or disruption compromises the infant's capacity to sustain interactive engagement, while maintaining self-regulation. In situations of ongoing disruption or misregulation, the balance between self- and mutual regulation will be disturbed as the infant will have to withdraw from interactive regulation in order to maintain self-regulation and the management of negative affect that the disruption produces (Gianino & Tronick, 1988; Tronick, 1989).

Tronick (1989) suggests that "the pathways leading to the varieties of normalcy and psychopathology derive from the divergent experiences infants have with success, reparation of failure, and the transformation of negative emotions to positive emotions" (p. 117). In situations of chronic interactive failure without repair, as seen in the infants of depressed mothers, the infant is forced to disengage from people and things to devote their regulatory capacity to managing the negative affect they are experiencing (Gianino & Tronick, 1988). When the infant begins to employ these self-regulatory behaviours automatically and inflexibly in order to avoid the anticipated experience of negative affect, these coping behaviours become defensive and pathological (Tronick, 1989).

## **2.5 INFANT RESEARCH APPLIED TO THE CLINICAL SITUATION**

Rustin (1997) proposes that "since psychoanalysis is a developmental process, there are links that can be inferred between infant and adult development that carry implications for the therapeutic action of psychoanalysis" (p. 59). In the words of Lyons-Ruth (1999) "both the analyst-patient and the parent-infant relationship share a focus on facilitating developmental change..." (p. 581). Rustin (1997) suggests that "the concepts emerging from infant research provide a new way of thinking about development, psychoanalysis, and therapeutic action" (p. 44). Both intersubjectivity theorists and infant researchers recognise "the analyst-patient relationship as the system that affects therapeutic action" (Lachmann, 2001, p. 183). Recognition of the centrality of this relationship to therapeutic change has led therapists to look more closely at the infant-mother dyad as it helps to illuminate analogous features of the patient-therapist dyad (Lyons-Ruth, 1998; Lyons-Ruth, 1999; Rustin, 1997; Sorter, 1996; Tronick, 1998).

Tronick (2001) emphasises that the therapeutic dyad is not exactly the same as the mother-infant dyad and cautions against applying “models of the mother-infant/child interaction to the therapeutic situation in a simple-minded, noncritical fashion” (Tronick, 2001, p. 189). He believes that there is much to be gained by comparing and contrasting the areas of infant research and psychoanalysis, but he highlights the importance of not assuming that pathology is a linear outcome of an infantile experience. Pathology can occur at any time in development and pathological early interaction structures can be transformed by later developmental experiences (Tronick, 2001; Zeanah et al., 1989).

Kiersky and Beebe (1994) agree that under optimal circumstances, the early patterns of interaction do become transformed by later symbolic elaboration and experience, but they argue that these early patterns persist and continue to act as a ‘template’ for later patterns of interpersonal relating. It is particularly important to consider the impact of early patterns of relatedness in patients who demonstrate rigid modes of self- and mutual regulation which have undergone very little transformation over time (Kiersky & Beebe, 1994). In these cases the therapist is likely to identify residual early interaction structures which manifest in the therapy.

Lachmann and Beebe (1996a, 1996b) apply the principles of dyadic regulation derived from infant research, through metaphor and analogy to the patterning of therapist-patient interaction. “The necessity for integrating both self- and mutual regulation in early development argues for their integration in a psychoanalytic theory of adult treatment as well” (Lachmann & Beebe, 1996b, p. 124; Beebe & Lachmann, 1998). Just as infant and caregiver co-construct their world, so do analyst and patient (Lachmann, 2001). The principles of interactive regulation do not address the dynamic content of clinical issues, which are always of importance to the clinician, “rather they address the process and patterning of interactions” (Lachmann & Beebe, 1996a, p. 3).

### **2.5.1 Ongoing self- and mutual regulation in the therapeutic context**

In the treatment situation, ongoing regulations describe the repeated, characteristic and predictable patterns of interaction between therapist and patient. These “ongoing regulations range from subtle nonverbal behaviors, such as postural and facial interchanges, intonations and tone of voice, and greeting and parting rituals, to verbal exchanges” (Lachmann & Beebe,

1996a, p. 4). Through the repetition of these interactions, characteristic adaptive or non-adaptive patterns of self- and mutual regulation are co-constructed (Beebe et al., 1992; Beebe & Lachmann, 1994, 1998; Lachmann & Beebe, 1996b). A close analysis of ongoing regulations, both verbal and nonverbal is akin to the frame-by-frame analysis of the mother-infant dyad, and can shed light on the process of therapeutic action and psychic structure formation (Lachmann, 2001). The structure of the interaction, irrespective of its verbal content, becomes the focus of attention. This micro-analysis has not usually been applied to the subtle nonverbal aspects of interaction in the treatment process (Lachmann & Beebe, 1996b; Knoblauch, 1997).

These elements of patient-therapist interaction were generally viewed as the early preliminary phases of therapy, thought not to contribute directly to structural change. Lachmann and Beebe (1992, 1996a, 1996b) believe that they do contribute directly to the formation and internalisation of representations. Ongoing regulations between patient and therapist “can promote new expectations and can constitute a mode of therapeutic action” (Lachmann & Beebe, 1996a, p. 5). The therapeutic action of ongoing regulations is the joint process of constructing new expectations and disconfirming old expectations.

### **2.5.2 Nonverbal aspects of the therapeutic interchange**

The practice of psychoanalytic therapy has privileged verbal communication, with the nonverbal domain receiving relatively little attention in psychoanalytic theorising (Knoblauch, 1997). Shifts to a relational perspective have drawn increased attention to the importance of nonverbal aspects of communication by both patient and therapist (Beebe & Lachmann, 1998; Knoblauch, 1997; Lachmann & Beebe, 1996b; Mitchell, 1988; Ogden, 1984; Pally, 2001; Warshaw, 1992). One of the valuable contributions of infant research is that it has “sensitized or resensitized us to the ongoing, often nonverbal and unverbally verbalized dimensions of the analyst-patient interaction” (Lachmann, 2001, p. 170). It is these aspects of the therapeutic interaction which become foregrounded when treating the so-called “difficult-to-reach...difficult-to-treat patient” (Lachmann, 2001, p. 183). These patients may be affectively disengaged or may have difficulty formulating their experience (Stern, D.B., 1994), semantic exchanges may be absent or experienced as empty and meaningless (Knoblauch, 1997). They may have difficulty with reflective function and may not be able to identify their own mental states and those of others (Fonagy & Target, 1998). Nonverbal aspects of the therapeutic interchange usually form an important background to treatment, but

with patients who illustrate highly restrictive modes of self regulation and where presymbolic, nonverbal ways of relating dominate the therapy, the nonverbal patterns and cues become necessarily foregrounded (Kiersky & Beebe, 1994). In these situations the therapist needs to be closely attuned to such issues as time, space, affect and arousal, both in the patient and in herself. Attention to the interaction between therapist and patient, particularly the processes of self- and mutual regulation, can help the therapist to make contact with the patient who is difficult-to-reach (Lachmann, 2001). Frankel (1998) makes a similar point in relation to play therapy by highlighting the value of focussing on self- and mutual regulation in situations where children demonstrate an inability to play.

On a nonverbal level, the unit of analysis is the interactive sequence, which includes both self and mutual regulation. As previously mentioned, the interaction structures are "*nonverbal, encoded, but not symbolically elaborated patterns of experience*" (Knoblauch, 1997, p. 493). This encoded experience is not given semantic meaning, but takes the form of an expectation for an interactive sequence (Knoblauch, 1997). This nonverbal, procedural level of experience is a continuous background aspect of the therapeutic interaction, and is to be distinguished from the verbal, declarative, explicit level which includes language and dynamic content (Beebe & Lachmann, 1998; Lyons-Ruth, 1998). Knoblauch (1997) suggests that "process contours, such as volume, tone, rhythm, tempo and visual cues give this patterning recognisable shape" (p. 493) which allow it to be cognitively stored and retrieved even though it is without semantic meaning.

There are various ways to work with the nonverbal cues and interaction structures that present in the treatment situation. One can either respond directly nonverbally, or one can translate the interaction sequence into a symbolic level by describing it with words (Knoblauch, 1997). Kiersky and Beebe (1994) use the latter approach. They utilise the nonverbal cues, such as gaze avoidance or movement away from the therapist, as a basis for inferring the nature of earlier interaction structures. Using clinical experience and knowledge of the mother-infant interaction literature, they were able to generate images of the patient as infant and to formulate "model scenes" (Kiersky & Beebe, 1994; Lichtenberg, 1989). These model scenes are co-constructed metaphors, capturing the patient's dynamic experience of early interactions. They serve as verbal interpretations and can be helpful in facilitating the analytic work where previous interpretive strategies failed.

Knoblauch (1997) uses the first approach to the nonverbal patterns in which the therapist's response on a nonverbal rather than a verbal level facilitates the therapeutic process. His approach is based on the premise that "a communication at the nonverbal level that is *encoded but not symbolically elaborated* into words cannot be used at the symbolic level" (Knoblauch, 1997, p. 498). This approach is similar to that of Lyons-Ruth (1998, 1999) who describes the role of procedural representations which are not symbolically based. In her view, the early patterns of interaction between infant and caregiver are stored as procedural knowledge, in other words, knowledge about how to do things, which is outside conscious awareness and attention (but not repressed) and which is not routinely translated into words and may never be given semantic elaboration. Lyons-Ruth (1998) labels the procedural knowledge about how to do things with others as "implicit relational knowing" (p. 284). Implicit relational knowing operates throughout life and is continually changed as new relational experiences occur (Lyons-Ruth, 1998; Stern, 1998). It is believed that "the vast majority of therapeutic change is found to occur in this domain" (Stern, 1998, p. 300).

### **2.5.3 The application of infant research to therapy with children**

Seligman (1998) points out that while clinical thinking about adult analysis has been transformed through the incorporation of ideas from infant research, child analysts have lagged behind in incorporating these findings into their clinical work and in generating new theories of therapeutic action. In his view "many child analysts remain snared in an awkward compromise with loyalty to constricting clinical theories and have failed to explicate the clinical implications of their own flexible approach to children and families" (Seligman, 1998, p. 79). Historically it was child analysts who provided insights into the developmental process through their analyses of children, but now it is the empirical infant researchers, who through direct observation are providing the most systematic and elaborate accounts of child development (Seligman, 1998). "Child analysis has thus become marginal to technical and theoretical discussions for which it was, at one time, utterly central" (Seligman, 1998, p. 80).

Recently, there has been an attempt to redress this deficit and a number of authors who work clinically with children, have begun to apply concepts emerging from infant research to their clinical work and theorising (Coates, 1998; Fonagy & Target, 1998; Frankel, 1998; Harrison, 1998; Seligman, 1997, 1998; Warshaw, 1992). Seligman (1997) suggests that many of the central features of clinical work with children make an integration with concepts from infant research particularly appropriate and relevant. Clinical work with children inevitably involves

working with their families and as “children’s lives are so obviously located in the social world” (Seligman, 1997, p 711), child therapists cannot avoid operating from within a relational systems perspective that is intrinsic to the ideas derived from infant research.

The significance of patterns of interaction between patient and therapist is extremely germane to child therapy. Child therapists inevitably use action and interaction as part of their clinical technique as “it is simply impossible to communicate with children without participating with them” (Seligman, 1997, p. 713). Frankel (1998) suggests that the essential processes and treatment mechanisms in adult psychotherapy are similar to those in play therapy. One of the central features is play, and the other is the “renegotiation of self-other relationships through action” (p.149). The model of therapeutic action proposed by Beebe and Lachmann is an example of the renegotiation of self-other relationships through action.

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## CHAPTER THREE

### METHODOLOGY

The purpose of this chapter is to describe the methodological approach that has been adopted for this study: namely a clinical case study within an intersubjective paradigm. This section will include a consideration of the purpose of this case study and a motivation for why it was undertaken; a discussion of the case study method in general and its application to this case; a discussion of the central tenets of intersubjectivity theory, the relevance of this paradigm for this case study and its impact on the procedures used for the collection of data.

A clinical study is presented which attempts to illustrate Beebe and Lachmann's (1994) hypothesis that ongoing patterns of self- and mutual regulation are pivotal in the formation of new expectations and organising principles, and constitute a mode of therapeutic action. Through the clinical material, I hope to illustrate that the patterns of interaction, expectations, and organising principles generated in this dyad were an emergent dyadic phenomenon, involving the contributions of both partners self-regulation and the mutually regulated responses emerging from this particular intersubjective field (Lachmann & Beebe, 1996a).

The motivation for using this child's material to illustrate this theory, grew out of the invaluable contribution of this theory in helping me to understand the patterns of nonverbal interaction which emerged during the course of the therapy and their role in bringing about psychic change. Confronted with significant improvements in the child's functioning over the course of a therapy in which subtle nonverbal interactions predominated, and in the absence of customary verbal interpretation of symbolic play, I was compelled to attempt to account for the processes that had led to this change. The vicissitudes posed by the clinical work with this child forced me to reflect on the effects of my own organising principles, including theoretical assumptions, on the unfolding process. The development in my understanding which brought about a shift in paradigmatic position was an essential part of my learning process in becoming a psychotherapist. It is hoped that this dissertation may be of use to other trainee therapists who are forced to grapple with similar issues.

The in-depth case study remains the principle research method for psychoanalytically oriented clinical work (Stolorow & Atwood, 1994). It has been used to generate theories of development, personality, psychopathology and therapeutic techniques (Edelson, 1984;

Kazdin, 1980). The case study method can be understood as the intensive study of individuals within a particular context (Bromley, 1986). Within clinical psychology this context is often the treatment situation (Kazdin, 1980). It attempts to present an account of "how and why a person behaved as he or she did in a given situation" (Bromley, 1986, p3) and inferences are usually drawn about factors arising from past or present that are likely to account for the current behaviour. The case study method includes certain essential features: it focuses on a particular pattern of behaviour within specific circumstances over a limited time-period; it aims to provide a selective but detailed description which captures the unique characteristics of the individual and his or her context, together with an analysis of the implications of these observations and lastly, it makes use of a case-law or theoretical framework which influences the organisation and interpretation of the data obtained (Bromley, 1986; Kazdin, 1980; Yin, 1994).

Kazdin (1980) suggests that the case study method is valuable in allowing clinicians to generate hypotheses around new therapeutic techniques which may emerge during the course of their work and enabling them to extend given techniques to a new problem or a new client population. He points out that the results yielded by the case study method are always suggestive and cannot be viewed as the definitive explanation for any particular phenomenon. The value of these results is that they can provide support for existing theory and that they can contribute to the development of theory construction (Kazdin, 1980; Stake, 1995). Edelson (1984) believes that psychoanalytic literature often fails to explicate clearly the objective that a particular study aims to achieve. The present case-study would be defined by Edelson (1984) as a theoretical single case study in the context of discovery which aims to define a theoretical concept and to show how it might be applied to a single case. It also contrasts the theory it illustrates with alternative theoretical conceptions which have been applied to explain the same phenomena. The objectives of this case study are to be distinguished from a case study in the context of justification, which aims to provide evidential support for an empirical claim (Edelson, 1984).

The play therapy described was carried out at the University of Cape Town Child Guidance Clinic. The clinic is a training facility which provides psychological services to the community, which includes assessment and therapeutic intervention for children experiencing a range of behavioural and emotional difficulties. The play therapy described is not psychoanalysis, but rather psychodynamic psychotherapy informed by psychoanalytic

principles. Stolorow et al. (1987) describe the fundamental aim of psychoanalytic therapy as “the unfolding, illumination, and transformation of the patient’s subjective world” (p. 9). It is their assertion that these transformational processes and their derailment always occur in an intersubjective context. The case material described was selected from a total of fifty-eight sessions spanning a twenty-one month period. The therapy was terminated, due to training requirements, at the end of the therapist’s final month of clinical training. The once-weekly sessions of 60 minutes duration were videotaped and a verbatim account was transcribed. Notes on countertransference responses were also documented following each session. In addition, 12 sessions were audiotaped during the second year, for use in supervision. Further details of the process of data collection and analysis will be included in the discussion on the intersubjective paradigm.

As described in the previous chapter, the concepts of self- and mutual regulation are derived from a dyadic systems approach to the caregiver-infant dyad (Beebe & Lachmann, 1994; Lachmann & Beebe, 1996a, 1996b). Beebe et al. (1992) suggest that while both self and object have been richly conceptualised in psychoanalytic theory, less attention has been paid to the role of the dyadic system. In order to study the patterns of ongoing self- and mutual regulation and the interactive effects of each partner on the other in the therapeutic dyad, a complete systems approach, such as that provided by the intersubjective paradigm is needed.

Within a systems approach, it is imperative to consider both partners’ subjectivities, composed of their respective organising principles and patterns of self-regulation as well as the intersubjective field in which various patterns of mutual regulation emerge. The intersubjective field is a system of “*reciprocal mutual influence*” (Stolorow, 1994a, p. 37) created by the interplay of the differently organised subjective worlds of patient and therapist. Intersubjectivity theory “is a field theory or systems theory in that it seeks to comprehend psychological phenomena, not as products of isolated intrapsychic mechanisms, but as forming at the interface of reciprocally interacting subjectivities” (Stolorow & Atwood, 1992, p.1). Within this broad methodological and epistemological stance, all psychological and clinical phenomena, including transference, countertransference, development, psychic structure, psychopathology, therapeutic technique and therapeutic action “cannot be viewed apart from the intersubjective contexts in which they take form” (Atwood & Stolorow, 1984, p.64).

It is important to emphasise that the patient's needs, subjectivity and healing are the focus of the therapeutic intervention, but although the treatment is for the benefit of the patient "the emotional history and psychological organization of patient and analyst are equally important to the understanding of any clinical exchange" (Orange et al., 1997, p.9). Each participant in the therapeutic dyad brings their own subjectivity and self-regulatory patterns to the encounter. Lachmann and Beebe (1996b) draw attention to the fact that in the therapist-patient dyad, as in the caregiver-infant dyad, the contributions of both partners are neither symmetrical nor equal. In the therapeutic situation the patient is there for relief from emotional distress and the therapist occupies the role of helper, healer and inquirer (Orange et al., 1997). The therapist should have a greater flexibility in self-regulatory range and a greater capacity for introspective reflection on the role of her own organising principles on the unfolding relationship. The therapist's theory and personal history are central aspects of her subjectivity which influences her contribution to the intersubjective field and shapes her capacity for empathic-introspective understanding (Orange et al., 1997). In order to fully comprehend the workings of a particular intersubjective field, "we must be much more self-revealing in describing clinical work than is typical in psychoanalytic writing" (Orange et al., 1997, p 10). Consonant with this view, I have chosen to present a formulation of certain of my own organising principles and patterns of self-regulation in Chapter 4, in an attempt to illustrate the effect of my own subjectivity in shaping the intersubjective field and in contributing to particular patterns of mutual regulation.

Kohut (1977) introduced the concept of empathy as a mode of data collection. By this he meant that the therapist attempts to understand the patient from within the patient's subjective reality (Wolf, 1988, 1989). In order to achieve this, the therapist needs to use vicarious introspection, "to put himself into the analysand's shoes so to speak, but not by asking himself what he, the analyst, would experience under these circumstances, but by asking himself what this particular patient— about whom he knows so much— would be apt to experience in this context" (Wolf, 1988, p. 20). Wolf (1988) suggests that we can gather data both from outside, "extrospectively" (p. 33) and through empathy, that is "vicarious introspection" (p. 33). From an intersubjective perspective, the mode of data collection is always based on empathic introspective inquiry. Through empathy the therapist investigates the principles which organise the patient's experience and through introspection, she reflects on the principles organising her own experience.

The data gathered for this study utilised both observation and empathic introspective inquiry. In terms of data gathered in respect of the patient, close observation of the non-verbal patterns of interaction and regulation and the process contours such as rhythm, facial cues and vocal contours which shaped these patterns were made during the sessions. Repeated review and close scrutiny of the video material allowed for a micro-analysis which produced further insights into the nature of these patterns, which were not always evident at the time of their occurrence. An empathic stance was used in conjunction with these observations, in order to understand the unconscious organising principles which structured the patient's experience. Supervision and study of the literature on self and mutual regulation were an essential part of the process of gathering data into the patient's subjectivity. Access to my own subjectivity and organising principles was obtained through observation of my own patterns of self-regulation and nonverbal interaction in the treatment situation. This was greatly facilitated through careful analysis of the video material. Vitaly important were the notes kept on countertransference experiences, including affects, arousal, attention, bodily and somatic experiences. Continual introspection, combined with supervision and my own personal therapy, allowed me to gather considerable data into the nature of my own organising principles and their role in co-constructing our mutual relatedness.

Contrary to research in which the observer is positioned outside of the observational field, within an intersubjective paradigm, the observer is always also the observed (Atwood & Stolorow, 1984; Kohut, 1984; Stolorow et al., 1987). Unlike methods of research which attempt to isolate, control and observe the various variables, such as the patient, the therapist and the impact of various techniques and theories, the intersubjective approach emphasises the relationship between the different variables as they impact on and shape each other. This view has profound implications for the knowledge produced in a psychoanalytic case study:

“The varied patterns of meaning that emerge in psychoanalytic research are brought to light within a specific psychological field located at the point of intersection of two subjectivities. Because the dimensions and boundaries of this field are intersubjective in nature, the interpretive conclusions of every case study must, in a very profound sense, be understood as *relative* to the intersubjective context of their origin”

(Atwood & Stolorow, 1984, p. 6).

In this type of research investigators are not able to claim that their knowledge, theory or interpretations have any ultimate validity (Thomson, 1991). Intersubjectivity theory questions

the assumption of an objective reality that can be known or uncovered by the clinician and cautions that the therapist's frame of reference and knowledge should not be "elevated to the status of objective fact" (Stolorow et al., 1987, p. 6). "All that can be known psychoanalytically is subjective reality – the patient's, the analyst's, and the evolving, ever-shifting intersubjective field created by the interplay between them" (Stolorow et al., 1987, p. 8).

Atwood and Stolorow (1984) argue that psychoanalytic case studies are always interpretive procedures and that the validity of their results can only be evaluated in terms of distinctly hermeneutic criteria. These include "the logical coherence of the argument, the comprehensiveness of the explanation, the consistency of the interpretations with accepted psychological knowledge, and the aesthetic beauty of the analysis in disclosing previously hidden patterns of order in the material being investigated" (Atwood & Stolorow, 1984, p. 5). The interpretation and meaning derived from the particular body of data described in this case study is fundamentally a subjective account. The processes of structure formation and therapeutic action described in this case are a unique phenomenon arising out of a specific intersubjective field to which both partners contributed their unique self-regulatory patterns. If the therapy had been conducted by another clinician, a very different pattern of interaction is likely to have resulted.

In a clinical study issues of confidentiality are especially significant. In this case study the child's name has been altered, together with certain demographic details. At the initial interview, the mother was informed, and accepted, that the clinic was a training facility and that material would be used for the purposes of teaching and research and could be shared with other clinicians. Aron (2000) describes the tension that exists for clinicians as they strive to protect the privacy of their patients while at the same time attempting to convey accurately the particular circumstances that contribute to the phenomenon in question. It is hoped that if the patient herself, were to read this one day, she would agree that the details provided were necessary to convey the essence of this particular experience and that she would accept that this has been written with respect and immense gratitude for the journey we made together.

## CHAPTER FOUR

### HISTORY AND FORMULATION

In this chapter I will provide an introduction to the patient, pertinent background history, information surrounding the initial assessment for therapy, the diagnosis, the treatment plan and the therapist's involvement with the family system. This will be followed by a formulation of both the patient's and therapist's salient organising principles and patterns of self- and mutual regulation. As discussed in the previous chapter, in order to consider the interactive effect of each partner in the dyadic system it is necessary to outline aspects of both their subjectivities in order to explore the workings of the intersubjective field. As the section on the therapeutic intervention will explore the process of change in Hannah's self-structure, organising principles and patterns of self- and mutual regulation, these aspects will be focussed on in this formulation. Whilst a number of psychodynamic factors contributed to Hannah's difficulties, these will not be elaborated on, as this formulation is intended to illustrate the patterns of early interaction and the organising principles derived from these.

#### 4.1 HISTORY

##### 4.1.1 Introduction to the patient

I met Hannah, who was eight years and ten months, in March 1998, when she was brought to the University of Cape Town Child Guidance Clinic, by her mother and grandmother, during my first year as an intern psychologist. My initial contact with her was in the context of a family intake interview. The session was extremely chaotic as her mother and grandmother tried to tell me about her difficulties and history over the crying and screaming of her two younger half-siblings (a brother aged two years and seven months and a sister aged 13 months), who had unpacked every toy in the playroom and needed to be taken to the toilet a number of times. Hannah sat almost motionless, on the edge of her chair, making little contact with any of her family as her mother described her as being "a problem not just for us, but for herself as well".

Mother initiated the referral because she was concerned about Hannah's "disobedience and destructive behaviour". She reported that Hannah did not listen when spoken to and often ignored requests for assistance with the younger children or with tasks in the home. Hannah refused to bathe, brush her hair or clean herself and these difficulties with self-care had begun

in 1997, intensifying in 1998, when mother left home to study. At around the same time she became reluctant to attend school, often refusing to go. She had poor relationships with her peers, had no friends and would often fight with other children. Mother believed that the fights originated from Hannah's bossy behaviour towards her peers and she described how Hannah would bribe her peers in order to maintain friendships. Hannah was also having nightmares, refused to sleep in a room of her own, was afraid of the dark and of being alone generally. She was reportedly fidgety and restless and was unable to sit still for long periods of time. Mother described Hannah's behaviour since the age of two, as destructive, citing examples of her breaking things in the home and fighting with her peers.

Hannah had been taken to the Red Cross Hospital Child and Family Unit in 1993 and 1996, but the family had never stayed for intervention, owing to financial constraints. Mother and grandmother initially tried to persuade her to listen to them and to do the things that she refused to do, but had resorted to shouting at her, locking her in the bathroom, putting her outside the house, hitting her, or threatening to send her away. At the time of referral, mother reported that she was feeling somewhat more able to manage, but said that in the past she had been so angry with Hannah that she "used to grab her round the neck and feel an urge to choke her". The referral was precipitated by mother feeling that grandmother was unable to shoulder the burden of Hannah's behaviour since she had moved out of the home.

#### **4.1.2 Family and developmental history**

Hannah's mother described her own childhood as "extremely difficult" as her mother was a full-time domestic worker and she was left in the care of her maternal grandparents. She had little contact with her father. Mother had a reasonably close relationship with her maternal grandparents. Her relationship with her own mother was difficult when she was younger as she felt angry towards her for not being available to care for her. Since Hannah's birth, mother has enjoyed a close relationship with her mother as she has come to rely on her for support with the children. Her grandparents died when mother was a young adolescent and she describes this as a major loss for her, which led to much rebellion. After her grandparents died, mother became involved in politics and left school in her Std 8 year, when her political involvement became full-time.

It was through her political activities that she met Hannah's father. According to mother, Hannah's father had an unhappy childhood and grew up with his mother, stepfather and four

half siblings. He had never known his own father and had a distant relationship with his stepfather. Paternal grandmother was described as a cold and unemotional woman who showed little interest in Hannah and had infrequent contact with her.

Mother and father met in 1988 and during the same year, father was detained and tortured. Mother describes him as a “a Jekyll and Hyde, fine one moment and not the next”. Prior to and during their marriage father was physically and emotionally abusive to mother, and at times towards Hannah. Mother recalled an incident in which he picked Hannah up while she was sleeping and threw her savagely onto the couch. Father frequently had rapid changes of mood and was possessive, suspicious and extremely domineering. He abused substances and drank heavily and this would exacerbate his violent behaviour.

When mother attempted to “baby” Hannah or was too attentive towards her, father would become jealous and enraged and this would precipitate the abuse. If Hannah cried for something and mother gave it to her, father would become enraged, take it away and say that mother was spoiling her. During times when mother was being beaten by father, Hannah would initially cry and when her cries were not responded to she would become lifeless and would appear to be sleeping. They would constantly move from house to house in an attempt to escape father. There were incidents in which mother ran out of the house to escape father leaving the infant Hannah lying alone for the evening. Father constantly threatened to kidnap Hannah and attempted to do so on a few occasions.

When Hannah was two years old, father was imprisoned for two years for criminal activities. During this time mother became increasingly depressed and had trouble sleeping. She was depressed at the time of Hannah’s birth, and this increased with the ongoing abuse. She sought therapeutic intervention and had six months of therapy during which she decided to leave father. Mother described herself as a bit of a loner, who does not have many friends and whose life is a series of chaotic events and crises. She reported that she struggles to relate to people as she generally finds it difficult to trust. She gave a history of anxiety and depressive symptoms as well those of Posttraumatic Stress Disorder. Her inability to keep the time of appointments and her reports of sleep disturbance, affective lability and difficulty in modulating her intense anger, suggested difficulties with self-regulation.

When Hannah was four her mother divorced her father, three months after his release from prison. Six months after their divorce, father was murdered. Mother told Hannah that her father had died, but cannot remember how she broke the news to her. Hannah was taken to his funeral where she saw her father's body in an open coffin.

After divorcing Hannah's father, mother met stepfather and became pregnant with her second child who was born shortly after their marriage. The marriage was not abusive, but stepfather was involved in criminal activity which mother found impossible to live with. When Hannah was seven, stepfather was arrested and imprisoned for theft and their second child was born whilst he was in prison. At the time of referral, he and mother had been separated for a year and a half and were in the process of getting divorced. This was a further loss for Hannah as he had tried to be a father figure to her, was very protective towards her and would often intervene when he felt that mother was treating her unfairly.

Hannah was an unplanned baby, whose presence forced her parents to marry. Mother described her health as generally fine during the pregnancy, except for kidney problems resulting from father beating her during the pregnancy. Hannah was born at full term in a natural, but long delivery. Mother found it difficult to adjust to the mothering role as she felt too young for the responsibility and experienced the baby as an "interference in her life". Hannah was bottle fed from birth and was described as a healthy and "mature" baby who was quiet and relatively undemanding, with early developmental milestones. She sat at four and a half months, stood without help at eight months, walked at ten months, and spoke clearly at sixteen months. She was toilet trained at sixteen months and there were no difficulties reported in this regard. Hannah was apparently a healthy child with no major illnesses, but she experienced stomach pain and headaches which generally occurred when she did not want to attend school. Hannah was a restless sleeper, with frequent nightmares which lasted the whole night. She was unable to recall the contents of the nightmares and they seemed to have no apparent precipitants. She occasionally walked in her sleep and on three occasions had unlocked the front door and walked outside. Hannah did not attend creche and was looked after during the week by her maternal grandmother. Her grandmother played a central caretaking function in Hannah's life from infancy and has been the most consistent presence in her life. As a result, Hannah has had the closest relationship with her, seeking her out when distressed and confiding in her at times.

Hannah began primary school at age five and feedback from the teachers indicated that Hannah had poor peer relationships, was disruptive in class, that her work was untidy and that her books were always torn. Despite these difficulties, Hannah had done reasonably well at school and there were no reports of problems with learning. Discipline was erratic and inconsistent with mother and grandmother differing in their approach. Mother reported that she is a disciplinarian whose style tends to be punitive and that grandmother compensates by not imposing any rules or structure. Mother did not have any knowledge of sexual abuse, but said that she had concerns regarding Hannah's paternal step-grandfather. Mother had discussed her concerns with Hannah who had denied any episodes of sexual abuse.

Mother reported having a very ambivalent relationship with Hannah since birth and has always "pushed her away", especially after her father's death. She always felt angry with Hannah for not being sufficiently independent, despite the fact that she had always been a "mature" child. Mother described feeling differently towards Hannah than towards her other two children. She has struggled to tell Hannah that she loves her, to express any affection towards her and to hug or hold her, saying that "it just does not feel right". Mother felt that this is because Hannah bears a striking resemblance to her father and is equated with him in her mind. She had been unable to communicate with Hannah and had often felt envious of grandmothers relationship with her. Hannah did not show much interest in her half-siblings, occasionally playing or fighting with her brother, but largely ignoring her younger sister. At the time of referral, with mother not living at home, the family were spending time together only at weekends. During the time that Hannah was seen for therapy, grandmother and the children moved in with mother. They described their financial circumstances as "extremely poor".

Hannah presented as a solemn, neatly dressed child of average height and build for her eight years. She wore faded, somewhat shabby blue jeans and a sleeveless blue checked T-shirt. An attempt had been made to tame her curly hair by braiding it tightly in two plaits, joined into one, which stood out from her head at a right angle. Her hazel eyes, set in a round baby-face, held an unfathomable expression. During the interview she seemed withdrawn and shy, answering few questions that were asked of her. She appeared detached and did not interrupt the discussion to add any spontaneous comment, but nonetheless appeared to be listening intently. She seated herself away from the rest of the family, on the edge of her chair with her body angled away from them. Intermittently she fidgeted with her hands, swung her foot

in a rhythmic manner and sucked her fingers. At times she would glance furtively at her mother or grandmother, but avoided any direct interaction with her family. She had to be prompted a number of times by her mother before engaging in any play and did not explore the room. Hannah was difficult to engage, and did not make conversation or volunteer any information spontaneously. She shrugged in response to questions that she found difficult to answer. She seemed a little anxious and rubbed her pencil between her fingers and occasionally put her fingers into her mouth. She spoke softly, did not smile and appeared sad and withdrawn during the interview. Her face lacked animation and her responses appeared mechanical.

Hannah was seen three times as part of an assessment to ascertain the best strategy for intervention. During this assessment a battery of projective tests including the Goodenough-Harris Draw a Person Test (scored for emotional indicators), the Kinetic Family Drawing the Bene-Anthony Family Relations Test and the Children's Apperception Test (C.A.T.) scored using the Bellak method were administered.

In summary; an assessment of Hannah's emotional state revealed signs of immaturity, anxiety and aggression. She experienced a lack of emotional engagement with her family and feelings of rejection which left her feeling isolated. Hannah viewed her environment as hostile, violent, non-responsive, intrusive and unpredictable and yearned for structure and routine. Parental figures were experienced as unpredictable, impinging, frightening and abandoning. The main needs expressed were the need to escape and withdraw, the need for protection and the need for parental nurturance. Central conflicts that emerged were around withdrawing and engaging, between taking in and rejecting nurturance and around parental figures. Anxieties centred around abandonment and physical harm and these were defended against by denial, repression, withdrawal and reaction formation.

In terms of the fourth edition of the American Psychiatric Association's (1994) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), Hannah was diagnosed on Axis I, with Dysthymic Disorder, Early Onset (300.4) and with a Parent-Child Relational Problem (V61.20). Other diagnoses on Axis I were considered but these were ruled out as the symptoms occurred during the course of a mood disorder. The possibility of a superimposed Major Depressive Disorder, was also considered, but it was not possible to assess whether her symptoms represented a distinct change from previous functioning. Significant psychosocial

problems were noted on Axis IV, including problems with her primary support group and economic problems.

#### **4.1.3 Treatment Plan and Parental Involvement**

In terms of management, it was decided that I would see Hannah for once-a-week play therapy for the duration of 1998, which was later extended through 1999, till January 2000. The initial goals of the treatment were to establish a therapeutic relationship with Hannah in which she could experience a safe, reliable and containing environment for the mobilisation of her thwarted selfobject needs. It was hoped that through an adequate and responsive selfobject relationship, Hannah's 'self' would experience greater cohesion and her symptomatic behaviour would be able to be explored and dealt with therapeutically. At the time of the initial assessment and the beginning stages of treatment, Hannah's symptoms were not considered in terms of difficulties with self- and mutual regulation, and the focus on these areas only emerged during the therapy.

Given the nature of Hannah's difficulties and the fact that many of her problems were rooted within the family system and were evidenced at school, I undertook to work closely with her teacher, her mother and grandmother. I was able to enlist her teacher's support for the treatment and had regular telephonic contact with her. This provided me with a different perspective on Hannah from the one I received from her mother and enabled me to monitor her progress in the classroom environment and with her peers. It was felt that the involvement and support of her mother and grandmother was essential if the therapy was to progress. Mother had initially expressed a wish to have therapy with me and expressed resentment that it should be Hannah who became my patient. Managing the decision to take Hannah into therapy required a number of sessions of precarious negotiation. Mother was referred for psychotherapy at another institution, but after attending sessions for two months, she stopped going, claiming that she did not have time and could not relate to her therapist.

From the outset, it was obvious that mother and grandmother needed parenting skills, particularly around structure and routine as well as alternative, non-punitive ways of dealing with Hannah's behaviour. They also needed help in understanding the meaning and cause of Hannah's behaviour, particularly re-framing her difficulties as having to do with depression, insecurity and anxiety as opposed to naughtiness and destructiveness. It was agreed that I would see mother and grandmother for six sessions of parent counselling and that we would

then meet at three monthly intervals for feedback and discussion. Initially, the parent counselling sessions were fruitful and focussed on two main areas: firstly helping mother and grandmother to deal with the practical aspects of parenting and helping them to institute structure and routine into her daily life; secondly helping them to identify her emotional states and naming and understanding these. After the first four sessions their attendance was erratic and I would see them infrequently, often when a crisis occurred, when mother was not coping or when I requested to see them for feedback.

A dynamic emerged over the course of the therapy which alerted me to the importance of managing the system as a whole, and the strength of mother's transference feelings towards me. When mother was feeling particularly uncontained or experienced herself as excluded from the therapeutic process, Hannah would not be brought to her sessions and I would have to establish telephonic contact with mother, deal with her anxiety and re-establish the connection between us. My contact with the family, allowed me to understand and experience some of the chaos and unpredictability that was Hannah's experience. They would often come to sessions late, or miss sessions without informing me, or Hannah would not be brought to her sessions, or she would arrive at the sessions without lunch, and even on occasion was sent to therapy with a younger sibling in tow. During the second year of the therapy, Hannah would make the relatively short journey to the child guidance clinic and home on her own. At times I intervened to ensure that she would get fetched and for a period of time during the winter months when it was dark, I drove her home on several occasions.

There were numerous changes and disruptions in Hannah's life during the therapy including grandmother and the children moving in with mother and Hannah moving to a different school. During the fifth month of the therapy, I was informed that Hannah was not attending school and in supervision, considered the need for intervention by a social worker. After much thought, it was felt that this could cause her further trauma and threaten the potential benefits of the therapy. At this point, I took a firm stance with her mother and grandmother, conveying my concerns and insisting on certain requirements, which they agreed to adhere to. As the therapy progressed and Hannah's symptoms improved, the family system appeared to settle and my pressing concerns about her well-being outside of the therapy receded.

## 4.2 FORMULATION: THE GENESIS OF TWO SUBJECTIVITIES

### 4.2.1 The patient

Hannah's presenting problems are primarily understood to result from difficulties with self-regulation and the management of negative and distressing internal states. These difficulties can be viewed as arising from a deficit in mutual regulation in her early development, with a consequent over reliance on self-regulation. The specific nature of the mutual regulation that she received would also have contributed to her self-regulatory style. Hannah's symptoms are indicative of an enfeebled and fragmented self-structure arising from an early environment in which her mirroring and idealising selfobject needs were not adequately responded to. Rigid and inflexible organising principles were created as a result of her early history and seem to have been minimally transformed through her later experience.

Hannah was an unplanned baby, whose birth forced her mother into a marriage with her father that was characterised by severe emotional and physical abuse. Mother describes her struggle to attach to and bond with her infant, experiencing Hannah as an interference in her life. The descriptions of mother's inability to hold or touch her child and in fact of literally "pushing her away" repeatedly would have impeded her capacity to facilitate the regulation of her child's physiological needs. Mother's depressed state at the time of Hannah's birth, her absorption with the vicissitudes of an abusive relationship and her own experience of inadequate maternal responsiveness would have mitigated against her providing her infant with assistance in regulating her affect, attention and arousal. This would have been compounded by her personality style characterised by impulsivity, an inability to self-regulate and difficulties in modulating intense affect. In addition, these factors would have contributed to her failure in being able to provide empathic and attuned responses to Hannah's mirroring selfobject needs. In fact, mother's identification of everything connected to her husband as bad, including Hannah, would have made it extremely difficult for her to recognise, affirm and validate her child's goodness. This would have affected Hannah's development of a positive sense of self-esteem and could explain her loss of interest in engaging in activities which are directed at care of the self. Father's violent and unpredictable behaviour also prevented her from the developmental second chance of an adequate response to her idealising needs as it is unlikely that she would have experienced him as an image of calmness and infallibility with which she could merge.

It is likely that Hannah's experience of mutual regulation would have been that it was unpredictable, either absent or intrusive, frightening and generally misattuned. Beebe and Lachmann (1994) describe the responses of depressed mothers towards their infants as "angry, poking, intrusive, and disengaged" (p. 141). Her parents' violent fights, her father's physical abuse of both her mother and herself and her mother's affectively charged behavioural style may have led her to expect responses that were intrusive, frightening and overstimulating. At the same time, her mother's continual rejection of her and the traumatic and repeated loss of her primary caregivers may have also led her to expect responses that were abandoning. It is possible to imagine how difficult it must have been for her to predict the nature of the responsiveness she would receive, but her expectation must have been of misattunement and misregulation. Her needs for attunement, responsiveness and attachment must have come to be experienced as frightening and dangerous, bringing intrusiveness, loss and even violence and the beginnings of an organising principle, confirmed by her later experience, was created which was that *attachment was to be avoided at all costs*.

Hannah's early interaction experience tilted her towards solitary self-regulation and away from interactive involvement. Beebe and Lachmann (1998) term the style of relating arising from this form of imbalance as "withdrawal" or "inhibition" (p. 485). Persistent attempts to elicit her caregivers' responsiveness and involvement in mutual regulation, proved futile and as in Tronick's (1989) "still-face" experiment where the infant is exposed to extreme interactive stress without repair, she seems to have expected disruption without repair, and responded by withdrawal as if giving up. Hannah's response while mother was being beaten, illustrate this pattern. She would initially cry in an attempt to be comforted, but when her cries were not responded to she would become "lifeless and would appear to be sleeping".

Hannah learned the importance of being a "quiet, relatively undemanding and mature baby" in order to avoid the trauma that the expression of her needs may bring. Hannah's early milestones are possibly indicative of a child who could not rely on a safe and stable environment to facilitate the emergence of her self, and who sensed her mother's ongoing wish that she would be "more independent". The organising principle generated within this context was that *she could not rely on another to aid her in self-regulation*.

Her preoccupation with solitary self-regulation was further amplified by the early expectation that attempts to elicit mother's involvement in mutual regulation, by crying, cooing, smiling or engaging in extended gaze behaviours, would provoke the envy, fury and abusive behaviour of father. This expectation led to an organising principle that *vitalising the other is dangerous and may lead to physical violence*. Consequently, Hannah developed a mechanical, affectively restricted and withdrawn interpersonal style. Hannah came to expect that she would be left with internal states of affect, attention and arousal which she would have to manage and regulate on her own. This further reinforced her withdrawn and constricted style of relating which enabled her to keep her affect, attention and arousal within tolerable limits.

Despite a preoccupation with solitary self-regulation, her self-regulatory strategies were failing her. Her self-neglect and refusal to bathe and clean herself along with her sleep disturbances are examples of her difficulties with regulating her physiological needs and arousal states. Her angry outbursts, fighting with her peers, her restlessness and anxiety around being alone are indicative of her difficulties with regulating her internal states of affect, arousal and attention. Hannah's "aggressive and destructive" behaviour may be also be viewed as by-products of a fragmented self and as an inability to manage the negative affect that she experienced as a result of chronic misregulation. Interestingly, collateral from Hannah's teacher differed from mother's description of Hannah. The teacher described Hannah as emotionally insecure and withdrawn rather than aggressive and destructive.

Hannah's later experiences of continually moving home, of the repeated and traumatic loss of her primary caregivers, of her mother and grandmother's inability to help her regulate and their contradictory and chaotic parenting styles further entrenched her organising principles and provided little opportunity for them to be transformed through alternative relational experience. It is possible that her self-regulatory methods became less adequate and her presenting problems increased as she experienced an increase in the interactive demands posed by peer relating and the classroom situation.

#### **4.2.2 The therapist**

In contrast to Hannah, I brought an entirely different subjectivity, self-regulatory range, mutual regulatory style and set of organising principles to our interaction. Where Hannah had come to believe that attachment was to be avoided at all costs, my early experience had

led to the formation of an organising principle that *attachment was essential and that establishing contact, imperative*. This had arisen from a background in which I was a long awaited child, born 11 years after my brother, following a number of miscarriages. By the time I was born, my mother had immersed herself in a demanding and fulfilling career, dealing with her previous multiple losses through a series of defences aimed at protecting herself from any further experience of loss. Her return to work within days of my birth, leaving me in the care of Nurse M, a rigid professional with very set ideas around “training baby”, was one of the ways of managing her anxiety around the attachment. Despite her apparent trust in Nurse and her seeming ability to be separate and absent, her concerns surrounding my wellbeing and very existence must have been conveyed to me. This fostered a particular style of interaction in which I reassured her of my presence through an animated, vitalising and engaging style. If I could make contact with her, and could respond to her selfobject needs, she was able to provide me with the appropriate responsiveness.

Compounding my need to be vitalising in eliciting responsiveness was my mother’s interactive style, which was particularly low-key and subdued, even appearing somewhat detached. This style had developed in response to the need to modulate and manage her own mother’s labile, intense and anxious affect states. My mother’s reserved and detached affective style was reinforced by her choice of career, which demanded detachment and objectivity in the face of extreme stress. Whilst for Hannah vitalising the other carried the threat of potential trauma, my own experience was that *I could connect and engage through vitalising the other*.

My early interactive experience tilted me towards mutual regulation, at times at the expense of self-regulation, a style termed by Beebe and Lachmann (1998), interactive vigilance. In fact I came to expect that if I could elicit the presence of a caregiver, I could expect my needs to be responded to in a relatively attuned manner. My method of self-regulation therefore involved reaching out to, attuning to and attempting to ensure the presence and maintenance of the other. The organising principle that emerged from this experience was that *I needed another to help me self-regulate*. The experience of multiple caregivers, including my father, all with varying selfobject needs, and differing styles of self- and interactive regulation, further honed my ability to attune to the needs of the partner and reinforced my interactively vigilant style. These patterns of early dyadic interaction left me with a broad affective range,

the capacity for facial expressiveness, a well-modulated voice, an outgoing and engaging manner and the capacity to amplify the affect of the dyadic partner.

While later relational experiences, including significant losses, confirmed some of these organising principles, others were transformed and alternative organising principles were generated and coexisted alongside the specific ones that I have described. Unlike Hannah, I had the opportunity for experiences, including psychotherapy that allowed me to expand and develop my self-regulatory capacities as well as facilitating a greater balance between self- and interactive regulation. Most importantly, I have a flexibility and greater range in both aspects of regulation, as well as a consciousness around these patterns and the situations which may influence my self- or mutual regulatory efforts.

Our two, very differently organised subjectivities, set the scene for the interactions which would evolve during the process of the therapy.

## CHAPTER FIVE

### THE CASE STUDY

In this chapter clinical material will be presented to illustrate how the evolution, transformation and repetition of ongoing patterns of self- and mutual regulation led to the formation of new expectations (psychic structure) in the patient and constituted a mode of therapeutic action. Whilst the disruption and repair of these ongoing regulations were also of significance in contributing to the formation of new expectations, these will not be illustrated as it was felt that the ongoing nature of the regulations was the predominant feature of the therapeutic process. The focus of this clinical section will be on the microanalysis of the patient and therapist's nonverbal patterns of interaction and the process contours, which structured and shaped these patterns. Attention will be paid to the alteration in the self-regulatory ranges of both patient and therapist and as a consequence of these changes, the transformation of the patterns of mutual regulation.

It is extremely difficult to divide the therapeutic process into phases, marked by particular changes or events or by a distinct difference in the relatedness between Hannah and myself. The changes in our patterns of relatedness and in Hannah's symptoms, expectations and organising principles was gradual and incremental, but for the sake of clarity, I have attempted to identify three stages in the therapeutic process, through which I hope to illustrate changes in patterns of self- and mutual regulation and show how the repetition of these ongoing regulations led to the emergence of new ongoing regulations and new expectations for relatedness. As the focus will be on the emerging nonverbal **patterns of interaction** and the effect of their repeated elaboration within the therapy, clinical material will be drawn from sessions in an often random and non-linear fashion in order to illustrate various aspects of our ongoing regulations and their transformation. The initial phase of the therapy, which I have termed, 'the meeting of two subjectivities', will cover a period of the first 7 months of the therapy. During this time, Hannah missed many sessions and university examinations and leave were added disruptions. The intermediate phase of the therapy, will be considered under the heading, 'towards transformation – the beginning of new patterns of regulation' and will focus on a period of time from the 7<sup>th</sup> to the 15<sup>th</sup> month of the therapy. In this section clinical material will be drawn from all phases of the therapy. The final section of the case study will fall under the heading 'new patterns predominate' and will use clinical material drawn from between the 16<sup>th</sup> and 21<sup>st</sup> months of the therapy.

## 5.1 THE MEETING OF TWO SUBJECTIVITIES

During the initial phase of the therapy, Hannah appeared frozen and her engagement with me was hesitant and erratic. She rarely made eye contact, usually gazing at the floor or out of the window. Whilst her gaze appeared unfocussed, I would occasionally notice her observing me out of the corner of her eye, or noticing some detail in the room that had altered since our previous meeting. She seemed to struggle with my gaze and its attendant expectation and would often appear uncomfortable, anxious and increasingly frozen. At times she would glance at me furtively and I would feel intense pressure to make a comment or ask her a question to facilitate the beginnings of some engagement between us.

She never initiated any conversation or any activity and I found myself to be the centre of initiative, asking, guiding or inviting her to engage with me or the play materials. Hannah did not appear particularly interested in any of the play materials, and did not engage in symbolic forms of play, using an object or myself to represent or express internal feelings or experiences. Playing was difficult for her and she would mostly engage in forms of "regressive play" (Mc Mahon, 1992, p. 9) which suggested a disturbance in her early sensory experiences. When painting, she would be more interested in the texture of the paint and water, which she would dip her fingers into. Play with playdough, involved the smell and texture of the dough, rather than an interest in making shapes or forms. She would paint a picture when presented with paint and paper, but it often felt as though she was doing so to please me, rather than deriving any intrinsic interest or enjoyment from the process. Consequently, I began to struggle to play and often felt inhibited, stuck and uncreative.

Hannah's capacity for affective expression was extremely limited. Her face remained immobile and expressionless and she rarely smiled. Her voice had little contour and she would often whisper her responses to me. Her manner was tentative and fearful and her speech was halting. A direct question would often yield a monosyllabic response, such as when I would ask her how she was, she would characteristically reply "fine". If I asked her what she wanted to do, she would usually reply "anything" or "I don't know". Our one-line interchanges sounded like gunfire and evoked images for me of an interrogation. There were pieces of dried food and sand in her hair, bits of food plastered to her face and her nails were blackened with dirt. The most overwhelming aspect of her physical presence was the smell of her breath, which seemed to fill the room and left me struggling to breathe. I felt that

nothing was happening, there was little dialogue, very little play and hardly any engagement between us. During this time my attention became drawn to the subtle non-verbal responses from Hannah. Some of these were sufficiently marked for me to notice them immediately, whilst others were repeated many times before I was aware of their patterning and significance. The more striking of these was her habit of holding her breath for long periods of time, often following a question from me, and another was her screwing up her eyes till they were shut in response to some of my questions or comments. Much of my understanding of these non-verbal cues developed retrospectively and much later in the therapy and came to be understood as aspects of self- and mutual regulation.

We spent much of the sessions in protracted periods of silence lasting anything from five to twenty-five minutes. The atmosphere in the room felt extremely tense and heavy, the time dragged on interminably and it was difficult to find a way of being with her which was comfortable. A typical interaction between us would be marked by my increasing discomfort and desperately intensified efforts as I tried unsuccessfully to engage with her, and Hannah's increasing withdrawal and persistent attempts to self-regulate. This is illustrated in the following vignette from session 3

S: How are you today?

H: Fine (*glancing at me briefly before staring at the floor*)

S: How has your week been?

H: *shrugs and turns to look at the clock*

S: You are looking at the time. Are you worried that you won't have enough time to do what you want to?

*Hannah shakes her head slowly and starts to tap her fingers on the table in a slow rhythmic fashion and stares at the floor. I watch her for a few minutes in silence, feeling unsettled by the constant tapping and concerned about whether the tapping indicates that she is anxious. I have no sense of what she is feeling and cannot read any cues from her face which is expressionless.*

S: What would you like to do today?

H: Anything (*whispering she shrugs her shoulders and glances at me fleetingly*)

S: Ok, but what would you like to do? (*I raise my pitch and my tone becomes more animated*)

*There are 5 minutes of silence during which Hannah continues to tap her fingers rhythmically and then changes the action to one of rubbing the edge of the table with her thumb as if trying to establish its texture and shape. During this time she is mostly looking at the floor, but once or twice she glances around the room as if searching for something. Her fingers that are rubbing the table are white at the knuckles from the pressure being exerted. Finally she whispers*

**H:** I'll paint. *(she makes no move towards the paints and the paper)*

**S:** Should we move the paints onto the floor?

*Hannah does not reply and I take this as affirmative and move the paints onto the floor.*

**H:** last week I saw I got paint on me when I got to my mom's house.

**S:** Really, what happened?

*Hannah does not answer me and begins painting.*

**S:** Were you worried that you would get paint on you today?

*Hannah ignores me and continues painting a sun and a blue sky. She crouches on her haunches leaning away from me and I lean towards her. There is a long silence while she paints a boat on the sea with a fish and a whale. The only sound in the room is the ticking of the clock and it seems to fill the room and make the silence more noticeable. Hannah is painting mechanically and seems detached from the painting. After painting in silence for about 15 minutes she sits back on her haunches, resting her head in her hand, with her elbow on her knee with a downward averted gaze.*

**S:** Do you want to tell me about the picture?

*Hannah does not respond, but begins to rock backwards and forwards on her haunches staring at the floor. I rephrase the question, altering my tone to one of enthusiastic enquiry.*

**S:** I wonder what's happening in this picture?

*Again Hannah does not respond directly and I begin to feel increasingly anxious as she continues to rock on her haunches, turns the paintbrush between her fingers and looks periodically at the clock. The silence feels tense and I find myself glancing at the clock and wondering how long to wait before breaking the silence again. I find that I am holding my breath and notice that she sighs heavily. I lean further towards her and peer at the painting helplessly. I begin to think about various questions to ask her and am aware of how hard I am trying. She glances at me fleetingly, but I cannot discern any affect, and I am unsure of what to say that will elicit a response from her. She seems to become increasingly anxious as she drums her fingers on the floor. I feel that the silence is increasing her anxiety and if I could find the right response she would feel less anxious.*

**S:** It looks like somewhere on the sea?

*Hannah closes her eyes, tilts her body further away from me, and takes a deep breath which she holds for a few seconds before sighing loudly. She clutches her knees with her hands, continues rocking and steals a quick expectant look at me. I feel that she is expecting a response from me, but at the same time is shutting me out. We sit in silence for another 15 minutes and she continues to bounce on her haunches and twirl her hair around her finger.*

**S:** Perhaps you don't feel like talking about the picture... would you like to do something else?

*Hannah appears frozen and does not respond. I feel that I am trying desperately hard, that I am hounding her, I say nothing and we sit together in the silence. The atmosphere in the room feels tense and it feels intolerable to sit in the room with her. The words that come to mind are heavy, dead, blank, paralysed, and immobilised. I cannot breathe...the room is filled with this terrible smell of sweat, bad breath and fear. I become overwhelmed by the need to sleep, feel my eyes closing and have to pinch my arm to force myself to stay awake. I finally get up and open a window as I have pins and needles in my foot and feel unbelievably uncomfortable. I am aware that I am rubbing my inner arm and that my fingers are resting on my pulse. Every minute feels like ten, and each time she looks at the clock, I find myself feeling both a panic for her about the time passing and a relief for me that the session is going to end. I am struggling to think about what is going on between us, to construct any understanding of her internal world. I feel immobilised and paralysed. There is a deadness in the room which feels like it is deadening me. I feel helpless, hopeless, rejected, pushed out, and incompetent. I find myself shifting about in my seat, changing my tone frequently, leaning forward towards her and then back, lifting my feet beneath me in an effort to find alternate ways of being with her. We spend the rest of the session sitting together in silence.*

At this time, I understood these strong countertransference experiences as communication via projective identification of her unbearable and unthinkable feelings and experiences. This theoretical perspective positioned me as a passive observer of Hannah's schizoid withdrawal and a neutral recipient of her projections (Guntrip, 1992). At this stage of the treatment, I had not yet grasped the intersubjective nature of the interaction between us and my role in co-constructing the transference and our patterns of relatedness.

In retrospect, and much later in the therapy, I came to view this interaction which typified our joint patterns of relating in the early phases of the therapy, as a non-optimal ongoing regulation (Beebe & Lachmann, 1994). These non-optimal ongoing regulations resembled the approach-and-withdrawal sequence described by Beebe et al. (1997) as “a chase and dodge” sequence (p. 164). At the time, I had understood Hannah’s increasing anxiety, illustrated by her tapping of her fingers, her gaze avoidance and her rocking and fidgeting to be a result of the silence and lack of contact between us. My response had been to intensify my efforts to engage with her and to fill the silence with questions or comments, designed to elicit a response from her and to reassure her of my presence. Unconsciously, I had elevated my tone and pitch, increased my facial expressiveness, varied my vocal contours and moved my body closer to her.

I had not yet grasped our different self regulatory styles and the interactive effect that we were exerting on each other. It was a while before I came to understand her nonverbal responses of finger tapping, watching the clock, gaze avoidance, talking in a whisper, closing her eyes in response to questions, holding her breath, her immobile face, constricted affect and withdrawal as drastic self-regulatory measures. Through observing the repetition of her nonverbal responses and our interactions over many months, I came to see that my responses towards Hannah were evoking her early expectations of intrusiveness, overstimulation and misregulation. Her drastic self-regulatory strategies and withdrawal were an attempt to keep her affect, arousal and attention within tolerable and manageable limits and to avoid the attachment- abandonment sequence which was integral to her early experience. In addition, her lack of expressiveness protected her from the anxiety that vitalising the other may lead to terrible violence and destruction. My response of increasing my efforts to engage with her and more subtly of elevating my range of expressiveness, was not helpful in aiding her in her self-regulatory attempts. Beebe and Lachmann (1998) suggest that “compensatory vigilance is a common response to a patient who is difficult to engage...(but) that very vigilance itself may disturb the interaction” (p. 501). Our interactive pattern was mutually regulated in that Hannah’s withdrawal and ‘dodging’ increased my ‘chasing’ and in turn, my ‘chasing’ increased her ‘dodging’. It was non-optimal in that initially, her withdrawal did not have the desired effect of dampening down my levels of affect and arousal to more closely match her own.

I also came to understand that my strong countertransferential feelings, particularly the physical and somatic experiences of tiredness, squirming in my seat, needing to open the window, taking my pulse, rubbing my inner arm and fiddling with my hair were my own difficulties with, and attempts to self-regulate in the absence of a mutually regulating partner. I also viewed these responses as the effects on my own self-regulation of having to unconsciously alter my usually expressive, animated and vitalising style in the face of her withdrawal and constriction. Beebe and Lachmann (1998) point out that when “analysts find themselves tilting toward self-regulatory behaviours, they can be alerted to the possibility of interactive stress, well before they might recognise it at a more conscious symbolic level” (p. 505). Given our two very differently organised subjectivities, it is not surprising, in retrospect, that the interactions between Hannah and myself during the early phases of our interaction were mismatched, misregulated and led to feelings of hopelessness in both of us.

At the same time as my responses must have activated her expectations of an attachment – intrusiveness sequence, they must have also evoked her early experiences of deprivation and non-responsiveness. I was unknowingly contributing to this by not only misregulating her through intrusiveness, but also through withholding. As a beginner therapist trying to learn the technique of psychotherapy, I stifled my human and intuitive responses and felt tied to the theoretical paradigm within which I was encouraged to work. In this ‘one-person’ paradigm, the frustration hypothesis was central, and dictated strict rules around the dangers of too much gratification, which may interfere with the unfolding of the transference and fuel her “insatiable needs” for responsiveness. Rather than participate in direct play, I was encouraged to interpret her need to have me play with her, as interpretation was valued above interaction (Ghent, 1995). Her requests to take paper or pictures home were refused, rather than explored and the “frame” assumed mythical proportions. Slavin (1997) suggests that a subtext of “fear of our feelings, brittle defensiveness regarding exposure to our patients, (and) adherence to an unwritten set of rules...pervades the way...psychoanalytically oriented clinical work is represented, taught, thought about, and practiced in many settings” (p.807). Training in psychoanalytically oriented therapy often involves a process of socialisation in which “otherwise bright, inquisitive and even challenging individuals become...submissive to views that violate their own basic common sense” (Slavin, 1997, p. 805).

This ongoing regulation of approach-withdrawal created certain expectations for both Hannah and me which organised our ways of being together. Hannah’s expectations were of

misregulation, intrusion, demands and misattunement. Thus our initial ongoing regulations served to confirm her expectations for relatedness. I began to expect to feel pushed out, rebuffed, rejected, hopeless and incompetent as a therapist. This increased my anxiety around providing Hannah with the correct responses and fuelled my interactive efforts. The feelings of inadequacy induced in me, made me dread the sessions and my own selfobject needs for mirroring became foregrounded. Our two subjectivities created an intersubjective field in which our organising principles brought us to an immediate “disjunction” (Stolorow & Atwood, 1992, p. 103). Stolorow and Atwood (1992) suggest that an intersubjective disjunction occurs when the therapist assimilates the patient’s material into their own very differently organised subjectivity and in this process misunderstands the meaning of the patient’s communication.

## **5.2 TOWARDS TRANSFORMATION - THE BEGINNING OF NEW PATTERNS OF REGULATION**

This section will attempt to describe how the non-optimal patterns of self- and mutual regulation were gradually altered and new patterns of more attuned, more closely matched and optimal ongoing regulations emerged. Through repetition these new patterns led to the formation of new expectations and alternate organising principles.

I began this phase of the therapeutic process more than somewhat confused about my role as a therapist, battling with strong countertransference feelings of hopelessness, incompetence, tiredness, frustration, paralysis and felt frankly defeated. Any verbal interpretations or reflections of possible feeling states were met with a total lack of comprehension on Hannah’s part and often worse, with an increase in her withdrawal and drastic self-regulatory behaviour. I was aware of the interactive misregulation of chase and dodge, but had not yet understood how my organising principles, my theoretical perspective and my nonverbal actions, in particular rhythm, vocal contour, spatial movement, arousal and intensity of affect had co-constructed our misattuned interaction.

The change in our way of relating, when it came, was gradual and largely out of my conscious awareness. The nonverbal, pre-symbolic ways of relating dominated the therapy and rather than viewing Hannah’s ongoing nonverbal self-regulatory behaviours as a background aspect of the therapeutic interchange, a distraction from the ‘real’ work of the

therapy, I found myself paying closer attention to these aspects of her behaviour. Similar to the approach of Kiersky and Beebe (1994), Knoblauch (1997) and Sorter (1996), I began to view Hannah's presymbolic nonverbal ways of relating as minimally modified versions of her early patterns of relatedness.

The process and patterning of our interactions became the central feature of the treatment (Lachmann & Beebe, 1996a, 1996b). I became more attentive to the dimensions of time, space, affect and arousal and the process contours such as rhythm, volume, tone, pitch, tempo and visual cues, which shape these encoded, but not symbolically elaborated patterns (Knoblauch, 1997).

Ongoing patterns of self and mutual regulation were evident in numerous "characteristic, expectable and repeated interactions" (Lachmann & Beebe, 1996a, p. 4) across the course of the therapy. Together we created rubrics, which were shared sets of unstated rules for how our interactions would proceed. I have grouped these interactions together in categories as follows: rituals of arrival and departure; opening and ending conversational gambits; characteristic ways of beginning sessions and activities; repeated sequences of play and games; characteristic ways of asking each other questions and of wondering out aloud; shared phrases that repeated themselves; consistent interactions surrounding the clock and characteristic patterns of nonverbal interaction.

It is difficult to express the rhythmic patterns of interaction in words, much the same as it is difficult to describe the thematic melody running through a piece of music. Our ongoing regulations became slowly transformed from mismatched and misregulated non-optimal regulations to more closely matched, optimal regulations in which I was able to use Hannah's cues to offer her the particular responsiveness that she was needing. Lachmann and Beebe (1996a) suggest that the structure of the interaction, with its corresponding regulatory influences should be the focus of study. Given this, I will not illustrate any one particular interaction, but will rather provide examples of the repeated patterns which emerged during this phase of the therapy. By way of illustration, I have selected to describe the patterns of gaze regulation, repeated sequences of play and games and our interactions around the clock. Through these I hope to illustrate the new patterns created through the alteration of my nonverbal responses and the subsequent effect this had on our relatedness.

### 5.2.1 Gaze regulation

At the beginning of the therapy I maintained constant eye contact with Hannah, despite her almost continual gaze avoidance, and my realisation that my gaze seemed to increase Hannah's frozen state. She would often close her eyes in response to a direct question. Occasionally Hannah would glance at me furtively, almost as if she wished for increased contact and yet the moment that our eyes met, she would retreat as if in terror. The image of a frightened creature caught in the headlights was a recurring one for me, but despite this I resolutely maintained direct eye contact. My desire to maintain eye contact was partly driven by my need to observe cues from Hannah which would enable me to attune to her more optimally and partly because my own experience with direct eye contact was that it facilitated engagement. In addition, in my attempt to be a 'good and competent' therapist I was following what I considered to be a basic and fundamental rule of technique, maintaining eye contact with the patient.

As I became increasingly aware of the effect of my gaze on Hannah, I found myself drawn to the moment to moment shifts within the sessions – to notice the moments when she would lift her eyes to meet mine, only to dart away when meeting my gaze, or when my gaze interrupted her play. It is not possible to isolate the moment when a new pattern of gaze regulation became established in the therapy, but in reviewing the video material, a new and repetitive sequence of gaze regulation emerged. The sequence unfolded as follows: Hannah would glance at me furtively and I would sense her nascent wish to make contact, to seek me out. I would then turn my gaze away from her in an attempt to allow her to make contact and she would look at me directly for a few moments while I was looking away. I would then scan back quickly to see whether she was ready to make eye contact and to warn her that my gaze would return. During this exchange our eyes would meet for a few moments before she would nod almost imperceptibly, knowing that I would return my gaze. She would then shift her gaze to the floor.

This pattern repeated itself countless times, with subtle variations, and I became more adept at sensing her need to look at me and engaging in a sequence which would facilitate this. As the pattern progressed, the time spent in mutual face-to-face gaze increased by small increments until we could sustain eye contact for a few seconds, and later for much longer periods of time. I was not following a deliberate plan of nonverbal responsiveness, but was rather drawn into a mutually co-constructed interchange and was adopting an approach

similar to the one described by Knoblauch (1997) in which the “analyst’s response on a nonverbal rather than a verbal level of communication facilitates the therapeutic process” (p. 494).

I came to understand that for Hannah, looking at me directly evoked a need for responsiveness which triggered her fears around a possible attachment-abandonment or intrusiveness sequence and furthermore, elicited her fears that vitalising and engaging with the other had the potential to lead to abuse. It is possible to speculate that as Hannah had learned to avoid engaging her mother in mutual gaze with heightened affect so as to avoid enraging her father, she repeated the same pattern with me in the therapy. My steadfast determination to maintain eye contact must have been experienced by her as intrusive, frightening and overwhelming and had only served to increase her need for withdrawal.

Initially Hannah sought out eye contact infrequently, but as this phase of the therapy progressed, she began to seek visual contact with regularity, and the periods of time spent in mutual gaze increased considerably. In addition to the extended time spent in mutual gaze the nature of the contact changed. Whilst initially I restricted my expressiveness during mutual gaze, not conveying much affect, over time, I began to respond to her increasing affective range by narrowing my eyes to convey pleasure or approval, or widening my eyes to express surprise or closing them slightly when struggling to understand something she was saying or to convey my increased attention. Communication at the nonverbal level is a continuous co-construction with each partner simultaneously affecting and being affected by the other (Knoblauch, 1997; Lachmann & Beebe, 1996b). This is illustrated in these alterations in affective expression, which were partly in response to her increased affective range, and partly shaped her affective responses. My visual contact with her as well as my affective range was more closely matched to her needs and range and our regulations were increasingly optimally regulated.

### **5.2.2 Repeated sequences of play and games**

In this intermediate phase of the therapy, I altered my stance of not participating directly in play with Hannah and interpreting her need to have me play with her, and acceded to her wish for reciprocal play.

*Hannah arrives at a session and produces a bottle of blowing bubbles*

**H:** The bottle came with two sticks.

**S:** Did you want me to blow with you?

*Hannah nods her head in response*

**S:** If I play with you, it feels like we are doing something together.

**H:** It feels better than doing something alone. (*nodding*)

I finally allowed myself to be drawn into the realm of the nonverbal and engaged with Hannah in wordlessly mutually co-constructed interchanges. To do this I had to suspend my 'need to know' and to risk contravening the 'rules'. There was a gradual, but noticeable shift in Hannah's manner, her play and the nature of our interaction. Hannah appeared less frozen, less mechanical, less detached and withdrawn and in fact began to be engrossed in the play, apparently deriving enjoyment from it and participating spontaneously. I noticed that I was able to sit more quietly, with significantly less discomfort and the pervasive experience of paralysis, deadness and my repeated need to shift position and to use self-touch in order to facilitate my own regulation diminished. I responded to her spontaneously and with a greater ease. In my reverie at the time the image of a mother-infant dyad came to mind as we played, silently, in a mutually shaped sequence of fine attunement and matching.

These sequences first emerged in our play with blowing bubbles which was repeated over many sessions and then extended to playdough, drawing, and games of noughts and crosses which she called "OXO" and another game "POP". Essentially the structure of the play was similar across these various modalities, with subtle variations and over time, developed to incorporate more dialogue and more complex series of interactions. I will describe the trajectory of development using the bubbles and the games of "OXO" and "POP".

The sessions would usually begin with my asking Hannah how she was, her customary response of "fine" and then further attempts on my part to engage her in conversation. This would usually unsettle her and she would begin to tap her fingers or look at the clock. I would then ask her what she wanted to do and rather than replying "anything" she began to suggest "bubbles", "playdough" or "OXO". With the bubbles our initial play was separate in that we each blew our own bubbles. The alteration in the play, when it came, was initiated by Hannah and I followed her lead. She started to blow bubbles for me to catch and return to her, so that our play altered from similar, but separate to a co-constructed exchange. I found

myself responding, out of awareness, to each of her movements, vocalizations, facial expressions and rhythms with a modification and matching of my own non-verbal actions and responses. She spoke very softly and I found myself closely matching her in tone, pitch and tempo so that, at times, I would be whispering without realising I was doing so. As she leaned towards me to blow me a bubble, I would respond with a corresponding arc of movement towards her and her slight rebound backwards, would be matched by a similar movement on my part.

I found myself matching her delighted giggles with spontaneous smiles and laughter of my own. Her vocalizations of “ooh” and “aah”, “ha” and “hee”, provoked similar spontaneous vocal displays from me and reminded me forcefully of a mother’s response to the pre-verbal vocalization of her infant. Knoblauch (1997) describes a similar non-verbal interaction with two of his adult patients in which he believed his spontaneous non-verbal responses to his patients was analogous to that described by Beebe in her research with infants in which she had “used the rhythms, tone, and volume of her vocalizations to modulate the infant’s level of distress and arousal” (Knoblauch, 1997, p. 502). The non-verbal responses of therapists in the facilitation of the therapeutic process has not been fully recognised (Knoblauch, 1997; Lachmann & Beebe, 1996b; Pally, 2001).

In retrospect, I now believe that Hannah’s withdrawal and constricted range of affect, arousal, vocal contour and gaze interaction had finally had the mutually regulating effect of dampening down my own self-regulatory style and range to levels that were tolerable to her. Consciously I felt hopeless and frustrated and had given up; unconsciously, I had altered my usual expressive and vitalising style to more closely match her own. I had kept my body still and slightly turned away from hers; my voice even and low, mostly whispering; had substituted words for vocalisations which closely matched hers and had not attempted to amplify her affective expression, but stayed within a narrow margin and moved in a similar direction to that which she was moving in. In addition, I focused more on my own regulatory responses and became conscious of relying less on mutual regulation. This alteration in my regulatory style had altered the interactive sequence and my responses must have been experienced as less intrusive, less stimulating and more optimally responsive.

Over time, Hannah introduced me to the games of “OXO” and “POP”. I was familiar with noughts and crosses but “POP” was her domain. It involved drawing a large grid with a

numerous blocks over a page and taking turns to try to fill up the blocks with either a 'P' or an 'O', each person continuing for as long as they were able to spell out "POP". With "OXO" and "POP" the structure of the play was that we drew the grids together. She drew all the vertical lines, I the horizontal. There would be a decision around colours, initially Hannah would say, "You choose", "You choose" and then she alternated "You choose, I choose". Although Hannah was very good at the games, she was initially reluctant to beat me, keeping a close record and ensuring that we always had the same score. "We're equal. We're equal" she would tell me. If there was a possibility of her beating me she would make silly moves to ensure that I won. During the games we sat closer together than we had during other times and added to the mutual vocalisations, were phrases from Hannah such as "I knew it! I knew it! I just knew that you would go there!" and "This is the way we play this, the same each time, the same, it's the same" and a running commentary between us of "my turn", "your turn", "me again", "you again".

Hannah grew genuinely excited by the games and excited by her skill and ability. Excitement was new to Hannah and often felt a little overwhelming at which point she would wriggle around in her seat and perhaps tap her fingers or hold her breath. At these times, initially out of awareness, I would slow the pace of the game down, make less comment, decrease my expressiveness and sometimes beat her. Over time, her capacity to tolerate an increased range of affect, arousal and attention developed and my comments of "Shew, that was good" or "Gee, you really got me there" or "I didn't see that" would elicit delighted giggles and squeals from her. Between turns we would make eye contact and I began to find myself mirroring her achievements and skill through my expressions and often with a gleam of pride in my eye. In response she would narrow her eyes with delight, cock her head and smile shyly.

As with the regulations around gaze, the repetitive and ongoing nature of the interactions allowed both Hannah and me to begin to develop new expectations of our ways of being together and to develop new and more optimal modes of self- and mutual regulation. There were times when disruptions occurred in the selfobject tie and when we would revert to old patterns of relating such as the approach and withdrawal sequence described previously. For me, it was the start of feeling needed by her, useful, helpful, effective, engaged with and valued. Hannah came to experience me as able to understand her, share in her feeling states, and was able to rely on my selfobject responses to strengthen her vulnerable self-structure

and to use my mutually regulated responses to aid her in the process of self-regulation. Beebe and Lachmann (1994) describe how the matching experiences that occur between caregiver and infant lead to the infant feeling attuned to, which can be viewed as the precursors of feeling known, understood and esteemed. In contrast to my previous attempts at empathy through reflection and verbal interpretation which made little impact on Hannah, and did not help in the mobilisation of selfobject transferences, the matching of process contours on a non-verbal level allowed her to feel attuned to and understood.

### **5.2.3 Interactions around the clock**

From the first session of the therapy my attention was drawn to Hannah's persistent and continual preoccupation with the clock and the passage of time. It was only later in the therapeutic process that I came to understand how the clock and her capacity to tell the time, functioned as a self-regulating mechanism for her. Initially, Hannah would swing round to watch the clock behind her as often as 15 times a session. I understood this as an indication of her reluctance to be in the room with me. My suggestions that perhaps the sessions felt long for her were met with a firm shaking of her head. Her continual watching of the clock left me feeling increased pressure to find a way to her. Her request to stay for half an hour longer in the 4<sup>th</sup> session, provided me with some insight into her anxiety about the sessions being too short.

As the therapy progressed my understanding about her ongoing absorption with the clock developed. I sensed that being able to tell the time was a skill, which served an important function for her and of which she was proud. Priel (1997) suggests that time is an intersubjective phenomenon and that timing and rhythmicity are central to mother-infant regulations. Experiences of misattunement and misregulation in the dimension of temporality will impact on the child's experience of being understood, its capacity to make meaning and its capacity to manage and tolerate levels of arousal and affect. The child's experience of presence and absence in their early life determine certain qualities of their later sense of temporality (Friedlander, 1997). Priel (1997) believes that "the perspective of an intersubjectively constructed sense of time also suggests that a patient's relationship to time can be viewed and analysed as any other relation brought into the treatment situation" (p. 445).

Rather than viewing her ongoing watching of the clock as an interference in the unfolding of the therapeutic relationship, I began to pay closer attention to this aspect of the developing non-verbal dialogue between us. I noticed an emerging pattern in which Hannah would swing round, glance at the clock and then back at me. I would then comment on her looking at the clock, and she would often tell me what the time was or how many minutes of the session were left. She responded to my invitation to draw a clock with noticeable enthusiasm. My affirmation of her skill in telling the time, clearly pleased her. In response to my comment that telling the time must be very helpful for her, she nodded with a look that conveyed her pleasure at being understood. Over the next 31 sessions, the clock remained central to our interactions. At times the anxiety around a separation from me or the loss brought about by the end of the sessions was prominent and the time seemed to fly for her “an hour feels like a minute and a minute feels like a second and a day feels like an hour.”

An interchange in the 26<sup>th</sup> session, provided further understanding into the role of her continual watching of the clock as an attempt to self-regulate. Shortly after I reminded her that we would be missing a session on a forthcoming public holiday, she turned and looked at the clock. I suggested that her worry around missing a session may have made her look at the clock. She nodded in agreement and said that she felt sad. I commented that I had come to know over the past year that she checked the clock whenever she felt worried about not having enough time or when something unsettled her or made her sad. I added that it was lucky that she had always been so good at telling the time. Her response “telling the time helps me to know when I am going to say goodbye to people and when to expect them to come” allowed me to further understand how being able to tell the time enabled her to create some order and predictability in a life filled with chaos and multiple disruptions.

As the therapy progressed I took on the role of commenting on the time that the session had begun, letting her know when half the session had passed, telling her how much time she had left when she wanted to begin a new activity and reminding her when there were 5 minutes left before the hour was to end. Her clock watching decreased to once or twice a session as she was more able to rely on the support of the mutually regulated responses in the therapeutic relationship.

This was illustrated in session 36, our second session in a new playroom in which a clock had not yet been installed. In the previous session she had commented on the absence of the

clock and we had agreed that this had been a critical piece of equipment for her during the previous 13 months. My response had been to organise a clock for the room and I waited for her to notice this throughout the session. At the end of the session she casually glanced at the clock after I reminded her that there were 5 minutes left. I commented that that we now had a clock and so she would be able to see for herself where we were in the sessions. She tilted her head to one side, smiled with a sense of imparting an important piece of news to me and informed me "I don't need the clock so much anymore... the clock is inside me now".

Through this sequence it is possible to see how Hannah's expectations of having to manage her anxiety around separation and loss on her own, were transformed into the beginning of the possibility that another person may be able to help her manage these anxieties. Self-calming and soothing were no longer relegated to solitary measures and she was less reliant on drastic attempts to self-regulate. This sequence over many sessions illustrates that self- and mutual regulation occur in tandem and affect each other. It is important to note that within this model the regulatory interactions with the other do not become inner regulations in a linear fashion. "Regulatory interactions and self-regulation proceed hand in hand and shape each other. Rather than viewing interactive regulations as transformed into self-regulations, existing self-regulations are altered by, as well as alter, interactive regulations" (Beebe & Lachmann, 1994, p. 156). The therapeutic action of ongoing regulations is the joint process of disconfirming old expectation and constructing new expectations which then become represented and internalised (Lachmann & Beebe, 1996a).

In addition to the factors within our dyadic system, other changes had occurred during this middle phase, which had altered the intersubjective field. I had finished my first year of clinical training and had begun supervision with a supervisor who was familiar with the concepts derived from infant research and was able to help me identify the patterns of interactive regulation and to provide a theoretical framework to understand the nonverbal regulatory patterns that I was observing. Together we began to unpack the 'rules' that I had accumulated during my first year of training and I began to liberate myself, not without guilt or confusion, from a theoretical paradigm that suggested strict rules of technique and embraced the frustration hypothesis of psychic structure formation. Slavin (1997) suggests that the "paradigm shift that has been taking place in psychoanalytic clinical thinking has not yet affected the training process because of the danger that the new paradigm might

undermine the safety, clarity, and ways of knowing that our traditional theories and clinical practices have provided” (p. 803).

Through supervision I was encouraged to follow and track Hannah’s responses more closely and to allow myself to respond more intuitively to her particular needs for responsiveness. Central to the change that occurred during this phase of the therapy, was my growing ability to become more conscious of my nonverbal responses towards Hannah and to understand them in terms of the dyadic regulation to which we were both contributing. I began to observe in minute detail what was happening, often slowing down the video recordings of the sessions, and later with the help of the concepts from infant research, was able to translate my purely intuitive responses into a model of therapeutic action. Fundamental to this was reflecting on my own organising principles, and coming to understand how my patterns of relatedness were co-constructing the transference and our joint relating.

### 5.3 NEW PATTERNS PREDOMINATE

In the final stage of the therapy, our repeated patterns of interaction became increasingly complex and verbal. It was clear that the new expectations and alternative organising principles generated by these patterns had become established and thus that psychic change had taken place.

The patterns of interaction, rituals and rubrics that we had developed over the previous 14 months continued to repeat themselves, with constant additions to our repertoire, particularly the advent of symbolic play and conversation. I began to comment on the patterns of interaction and the observations I had made about her and the changes in her way of being with me. I frequently used the phrases, “You know what I have come to know about you...”, or “I notice that...” or “Do you remember...”. I would comment on our characteristic patterns of gaze regulation, looking at the clock or rituals of arrival and departure: “I have come to know that sometimes when I ask you a question which feels too hard, you close your eyes or hold your breath” and “I wonder what made us both look at the clock right now”.

My comments were usually directed towards aspects of the interactions which were currently unfolding or which had been part of our previous experience. They did not extend to examination of her early patterns of relatedness and did not presume to know aspects of her

experience that had not been illuminated through our interactions. In this way my interventions were “based on a postulate that the meanings to a patient’s experiences are emergent properties of the analytic process as intersubjective context, and in that sense cannot be known prior to the unfolding of a particular process within a particular context” (Knoblauch, 1997, p. 512). Over time, she became an active participant in these musings and would also comment on my actions and responses. She was very astute and began to read and anticipate my responses. She would say “I know that you’re thinking, ‘cause sometimes when you think, you turn your head to the side and close your eyes a little” or “I knew you were going to do that, I knew from all the other times” or “sometimes when you are tired, you rest your face on your hand”. We spent much time reflecting on our joint history and she took great interest in working out the number of times and months we had spent together, recalling what we had done.

My interventions developed into helping her to identify and name particular feeling states. At times I wondered aloud about what she may be feeling, or used my own feelings to model for her. She was often unable to give a name to states of arousal or affect, but nodded her agreement when I identified her ‘squirminess’ prior to Christmas as excitement, or her biting her lip as worry. Sander (1983a) suggests that with the advent of symbolic functioning, difficulties with self-regulation are illustrated by an inability to access and articulate inner states.

At this stage her capacity to tolerate more intense levels of affect was increasing, along with her increasing range of expression and range of vocal contours. Her nonverbal self-soothing mechanisms generally emerged only in response to a particular crisis. I, in turn, was affected by her increased range and was able to display my more characteristic range of expressiveness, affect and vocal contour. Within the dyadic system of our relationship, I was less interactively vigilant and she was increasingly interactive.

While I had participated in these ongoing regulations, often wordlessly for months, I had originally viewed them as a preliminary aspect of the therapeutic work and had not been certain of how these repeated interactions would be mutative or how they constituted therapeutic action. What was certain however, during the last 7 months of the therapy were the dramatic, observable changes in Hannah, both inside and outside of the playroom. In describing the eventual changes in Hannah, the gradual and often imperceptible nature of the

process, must be emphasised. However, during this final phase of the therapy, there was a burgeoning of new developments on an almost weekly basis. She had become meticulous in her self-care and cleanliness and was very conscious of her appearance, enjoying dressing in the latest styles. She no longer had nightmares or sleep disturbance, was able to sleep on her own, was less fearful generally and there were no longer any problems with discipline. Her depressed mood had lifted significantly. Her relationships with her mother, grandmother and siblings were very much improved, and times spent together had become mutually enjoyable. Reports from school were that she was attentive, was doing well scholastically, had formed a close relationship with her teacher and her peer relations had improved enormously. She had even made a number of close friends.

I was staggered by the intensity and enthusiasm with which Hannah had engaged with the world as well as her resourcefulness and clearly evident sense of agency. Rustin (1997) suggests that the patient's experience of successfully influencing the therapist to respond in ways that are felt as more optimal, enhances the development of the patient's sense of agency. On her own initiative, she attended a weekly youth group, became involved in extra-mural activities and school events, visited the library regularly and had persuaded the librarians to read to her on each visit. During holidays she participated in an art course and created innovative works, which she delighted in giving me as gifts. Neighbours, her mother's friends, teachers and youth group leaders began to seek out contact with Hannah and she would often tell me of the developing relationships with new adult figures in her life.

In the playroom, Hannah became increasingly engaging, excited by our play, interested in me and my opinions and feelings, verbal, creative and would offer spontaneous glimpses of her inner experience and feelings. She spoke about the losses she had experienced, particularly of her father and the sadness and loneliness she had felt when we first met. In supervision, I referred to this time as "show and tell" as she almost invariably brought me things she had made, or told me of her achievements, seeking my praise. The presence of a mirroring selfobject transference was very apparent, as were her idealising and twinship needs (Wolf, 1988). I featured in all her paintings, my hair was "the nicest brown you could get", my "handwriting the best", my playroom "a magical garden where things could grow". When Hannah found words to express herself, she revealed an understanding of metaphor and a turn of phrase which, given our limited verbal interchange, was unexpected. In describing her isolation, loneliness and sadness at the start of the therapy, she told me that she thought of

where she was then as “the island of the living dead”. She likened the therapeutic process to “a walk through time”, a phrase that captivated her from a book she had read. In these ways, I was increasingly aware of the richness of her internal world.

The process of change does not imply that existing organising principles are altered or eliminated, but rather that alternative principles gradually emerge (Stolorow & Atwood, 1992). It was clear, that in large part through ongoing patterns of regulation, new expectations and alternative organising principles had become established. These changes were illustrated in numerous ways. Her continual refrain of “I know you, I know you” suggested that, unlike her early experiences of unpredictable responsiveness, Hannah felt able to predict the responses she would receive. Her gleeful comments of “you know me, you know me” demonstrated that she felt understood in ways that she had not before. The change in expectations was also evident in the alteration in the ritual of my collecting her from the waiting room. Initially, she would be sitting in the furthest corner with a book covering her face and I would have to seek her out. I would have to call her name a number of times before she would look up and she always seemed surprised to see me. At the end of the therapy, Hannah had moved out from the waiting room into the entrance lobby and always stood and stepped towards me as I went to collect her. The image it evoked was of an infant standing in a cot with arms raised, certain in the expectation of being held.

The termination, which was premature due to training regulations, was difficult for Hannah and brought many of her old organising principles to the fore. We were both aware that for her it was just the beginning, that ideally she needed more time for the new patterns to become further entrenched. Hannah expressed this in our final session; “I’ve thought about when I see you again...I might be like I was when I came”. In response to my question about whether she thought that she would return to that state, she replied quickly and with conviction, “No, because it’s been two years that I’ve spent changing...so I don’t think so”. Theoretical questions about the process and nature of structural change is the domain of clinicians and theorists, we can only really know of this change, through the subjective experience of our patients.

## CHAPTER SIX

### CONCLUSION

This dissertation has drawn attention to the contribution of infant research to an alternative view of development, psychic structure and therapeutic action. It has contrasted the view of “frustration in one form or another as the royal road to psychic structure formation” (Lachmann, 2001), with the proposal that psychic structure can develop through a multiplicity of routes (Beebe and Lachmann, 1994). Clinical material drawn from a therapy with an eight-year-old child, has been used to illustrate the role of one particular route, ongoing self- and mutual regulation, in the development of alternative organising principles.

Working with a child who is unable to express her inner experience through play or through words, and who is withdrawn and difficult to contact, can be a challenging experience for any clinician. For a beginner therapist, with little clinical experience, working with Hannah was at times an unsettling and arduous experience. The theoretical framework that informed my initial work with Hannah, together with its technical prescriptions, was of little value in helping me to understand Hannah’s subjective experience or to know how to respond. Feeling mired in an impasse, and certain only that I did not know how to proceed, I allowed her to draw me into the realm of the nonverbal and began to ‘listen’ to the unspoken dialogue that was developing between us. It was the watching and the listening, together with my subsequent attempts to find a theoretical explanation for the unfolding process, which led me into the work of infant research and its interface with psychoanalytic theory. Unknowingly, I was propelled into a paradigm shift which Slavin (1997) describes as “a real revolution in psychoanalysis” (p. 812).

This shift in perspective takes the view that the “analytic process is a two-person transaction, mirroring current views on infant development, in which the analyst is as subject to influence by both internal processes and the other, as is the patient” (Slavin, 1997, p.812). Through their integration of self- and mutual regulation, Beebe et al. (1992) propose “a model of transference and structuralization in adult treatment which integrates the simultaneous contributions of the patient-analyst interaction (the two-person psychology perspective) with the enduring structures from the patient’s past...(the one-person psychology perspective)” (p.75). The therapeutic process involves a continual dialectic between repetition, as evidenced by rigid inflexible organising principles and patterns of regulation, and

transformation, in which new patterns of self- and mutual regulation and alternative organising principles can emerge (Lachmann, 2001).

The shift in paradigm had a profound effect on my work with Hannah, as well as a lasting impact on my theoretical understanding, my view of technique and therapeutic action. Furthermore, this perspective has broader implications for models of learning and training (Slavin, 1997). Within this paradigm, the therapeutic process is viewed as one "in which the patient constructs the analyst's responsiveness to provide the kind of healing relationship that the analyst cannot know, a priori, how to provide" (Slavin, 1997, p. 813). In this process "the analyst's task is to be influenced in a co-constructed relationship, within which understanding may occur and be conveyed or, in another sense be created" (Seligman, 2001, p.201).

This theory contributes to our understanding of therapeutic action by emphasising the plurality of mechanisms involved in effecting psychic change. In particular it has encouraged us to look beyond the verbal content to the perception-action (procedural) level of the interaction and to attend to and recognise the ephemeral moment-by-moment shifts in affect, attention, arousal and timing in both partners as they jointly construct their mutual relatedness (Beebe et al., 2000; Lachmann, 2001; Pally, 2001; Seligman, 2001). This model encourages therapists to continually attend to their own nonverbal responses and self-regulatory strategies, and to recognise the ways in which their responses on a nonverbal level can impede, or facilitate the therapeutic process. As illustrated in this case study, therapists need to constantly reflect on the ways in which their organising principles, including their theoretical assumptions, are involved in shaping the unfolding process.

The patient-therapist relationship itself, rather than what is technically done in it, becomes the focus of attention. Technique is no longer viewed as a universal phenomenon that can be applied from one case to another, but rather viewed as something emerging from a unique intersubjective field. From this perspective, techniques such as interpretation or empathic attunement are not viewed as a source of change in and of themselves, but are rather considered in terms of how they contribute to the developing relationship and whether they facilitate the patient's sense of feeling understood.

Despite the implications of the paradigmatic shift that is taking place within psychoanalytic theory, training and supervision often does not equip clinicians to work within this relational

paradigm. Training and supervision from within a more 'one-person' model often encourages the belief that there is objective truth to be known about the workings of the patient's inner world, and specific techniques which should be employed in conveying this knowing to the patient. For trainee therapists who may be anxious about their lack of experience and their state of not knowing, this clarity and certainty together with certain proscriptions may be experienced as containing. Theoretical understanding is essential in informing clinical practice and serves an important function in containing and supporting clinicians. It is important however, that theory does not constrain the clinician and does not obscure possible meanings that may emerge during the therapeutic experience. Whilst the accumulated wisdom derived from extensive clinical practice is an important aspect of what should be conveyed through training and supervision, these learning processes should proceed within a context of discovery. From the perspective of a relational systems paradigm, training and supervision should be a mutually co-constructed process, embarked upon by two people who do not yet know, and who are committed to joint exploration. Within this paradigm, teaching and supervision should support the therapist as she becomes "carried by the patient's influence into a complex relational interaction"(Slavin, 1997, p.813) and should encourage the therapist to allow this to happen, rather than attempt to avoid it. Perhaps the most important role of supervision is that it should facilitate the therapist's "capacity to trust, without prior certainty, that what emerges from within will be therapeutically relevant and in the patient's best interests" (Slavin, 1997, p.815).

It is hoped that this dissertation has illustrated how, in allowing myself to be influenced by the patient, I was propelled into a paradigmatic shift which allowed new meaning to emerge in the therapeutic relationship and which facilitated a deeper understanding and more attuned mode of responsiveness. The writing of this dissertation has played a vital role in consolidating and integrating this new understanding and has been an important aspect of the learning involved in becoming a psychotherapist. It is hoped that this dissertation will contribute to the evolving understanding of the relevance of infant research to clinical work, particularly with children. Furthermore, it is hoped that other trainee therapists will benefit from this exploration of the processes that effect psychic change, and will be encouraged to hear the unspoken dialogue, within which meaning unfolds in the moment-to-moment exchange.

## REFERENCES

American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders. (4<sup>th</sup> ed.). Washington, DC: Author.

Aron, L. (2000). Ethical considerations in the writing of psychoanalytic case histories. Psychoanalytic Dialogues, 10 (2), 231-245.

Atwood, G.E., & Stolorow, R.D. (1984). Psychoanalytic inquiry book series: Vol. 4. Structures of subjectivity: Explorations in psychoanalytic phenomenology. Hillsdale, NJ: The Analytic Press.

Bacal, H.A. (1985). Optimal responsiveness and the therapeutic process. In A. Goldberg (Ed.), Progress in self psychology: Vol. 1. (pp. 202 – 227). New York: Guilford Press.

Bacal, H. A. (1988). Reflections on “optimum frustration”. In A. Goldberg (Ed.), Progress in self psychology: Vol. 4. Learning from Kohut (pp. 127-131). Hillsdale, NJ: The Analytic Press.

Bacal, H.A., & Newman, K.M. (1990). Theories of object relations: Bridges to self psychology. New York: Columbia University Press.

Basch, M. F. (1995). Kohut's contribution. Psychoanalytic Dialogues, 5(3), 367-373.

Beebe, B., Jaffe, J., & Lachmann, F.M. (1992). A dyadic systems view of communication. In N.J. Skolnick & S.C. Warshaw (Eds.), Relational perspectives in psychoanalysis (pp. 61-81). Hillsdale, NJ: The Analytic Press.

Beebe, B., Jaffe, J., Lachmann, F., Feldstein, S., Crown, C., & Jasnow, M. (2000). Systems models in development and psychoanalysis: The case of vocal rhythm coordination and attachment. Infant Mental Health Journal, 21(1-2), 99-122.

Beebe, B., & Lachmann, F.M. (1988a). Mother-infant mutual influence and precursors of psychic structure. In A. Goldberg (Ed.), Progress in self psychology: Vol. 3. Frontiers in self psychology (pp. 3-25). Hillsdale, NJ: The Analytic Press.

Beebe, B., & Lachmann, F.M. (1988b). The contribution of mother-infant mutual influence to the origins of self- and object representations. Psychoanalytic Psychology, 5 (4), 305-337.

Beebe, B., & Lachmann, F.M. (1992). The contribution of mother-infant mutual influence to the origins of self- and object representations. In N.J. Skolnick & S.C. Warshaw (Eds.), Relational perspectives in psychoanalysis (pp. 83-117). Hillsdale, NJ: The Analytic Press.

Beebe, B., & Lachmann, F.M. (1994). Representation and internalization in infancy: Three principles of salience. Psychoanalytic Psychology, 11 (2), 127-165.

Beebe, B., Lachmann, F., & Jaffe, J. (1997). Mother-infant interaction structures and presymbolic self- and object representations. Psychoanalytic Dialogues, 7(2), 133- 182.

Beebe, B., & Lachmann, F.M. (1998). Co-constructing inner and relational processes: *Self- and mutual regulation in infant research and adult treatment*. Psychoanalytic Psychology, 15(4), 480-516.

Behrends, R.S., & Blatt, S.J. (1985). Internalization and psychological development throughout the life cycle. The Psychoanalytic Study of the Child, 40, 11-39.

Brazelton, T.B., Koslowski, B., & Main, M. (1974). The origins of reciprocity: The early mother-infant interaction. In M. Lewis & L.A. Rosenblum (Eds.), The origins of behavior: Vol. 1. The effect of the infant on its caregiver (pp. 49-76). New York: John Wiley & Sons.

Bromley, D.B. (1986). The case-study method in psychology and related disciplines. Chichester: John Wiley & Sons.

Coates, S.W. (1998). Having a mind of one's own and holding the other in mind. Psychoanalytic Dialogues, 8(1), 115-148.

Demos, V. (1983). Discussion of papers by Drs. Sander and Stern. In J.D. Lichtenberg & S. Kaplan (Eds.), Psychoanalytic inquiry book series: Vol.1. Reflections on self psychology (pp.105 – 112). Hillsdale, NJ: The Analytic Press.

Doctors, S.R. (1996). Notes on the contribution of the analyst's self-awareness to optimal responsiveness. In A. Goldberg (Ed.), Progress in self psychology: Vol. 12. Basic ideas reconsidered (pp. 55-63). Hillsdale, NJ: The Analytic Press.

Edelson, M. (1984). Hypothesis and evidence in psychoanalysis. Chicago: The University of Chicago Press.

Emde, R.N. (1983). The prerepresentational self and its affective core. The Psychoanalytic Study of the Child, 38, 165- 192.

Emde, R.N. (1988a). Development terminable and interminable: I. Innate and motivational factors from infancy. The International Journal of Psycho-Analysis, 69, 23-42.

Emde, R.N. (1988b). Development terminable and interminable: II. Recent psychoanalytic theory and therapeutic considerations. The International Journal of Psycho-Analysis, 69, 283-296.

Fonagy, P. (1998). Moments of change in psychoanalytic theory: Discussion of a new theory of psychic change. Infant Mental Health Journal, 19 (3), 346-353.

Fonagy, P., & Target, M. (1998). Mentalization and the changing aims of child psychoanalysis. Psychoanalytic Dialogues, 8 (1), 87-114.

Fosshage, J.L. (1992). Self psychology: The self and its vicissitudes within a relational matrix. In N.J. Skolnick & S.C. Warshaw (Eds.), Relational perspectives in psychoanalysis (pp. 21-42). Hillsdale, NJ: The Analytic Press.

Frankel, J.B. (1998). The play's the thing: How the essential processes of therapy are seen most clearly in child therapy. Psychoanalytic Dialogues, 8 (1), 149-182.

Friedlander, S. (1997). "Once upon a time..." is a good start, but once is not enough: Commentary on paper by Beatriz Priel. Psychoanalytic Dialogues, 7 (4), 451-458.

Ghent, E. (1995). Interaction in the psychoanalytic situation. Psychoanalytic Dialogues, 5 (3), 479-491.

Gianino, A., & Tronick, E.Z. (1988). The mutual regulation model: The infant's self and interactive regulation and coping and defensive capacities. In T.M. Field, P. M. McCabe, & N. Schneiderman (Eds.), Stress and Coping (pp. 47-68). Hillsdale, NJ: Erlbaum Associates, Inc.

Greenberg, J.R., & Mitchell, S.A. (1983). Object relations in psychoanalytic theory. Cambridge, MA: Harvard University Press.

Grotstein, J.S., & Rinsley, D.B. (Eds.). (1994). Fairbairn and the origins of object relations. New York: The Guilford Press.

Guntrip, H. (1992). Schizoid phenomena, object relations and the self. London: Karnac Books and the Institute of Psycho-analysis. (Originally published in 1968).

Harrison, A.M. (1998). The case of Sophie. Infant Mental Health Journal, 19 (3), 309-314.

Horner, T.M. (1985). The psychic life of the young infant: Review and critique of the psychoanalytic concepts of symbiosis and infantile omnipotence. American Journal of Orthopsychiatry, 55 (3), 324-344.

Kazdin, A.E. (1980). Research design in clinical psychology. New York: Harper & Row.

Kiersky, S., & Beebe, B. (1994). The reconstruction of early nonverbal relatedness in the treatment of difficult patients: A special form of empathy. Psychoanalytic Dialogues, 4 (3), 389-408.

Knoblauch, S.H. (1997). Beyond the word in psychoanalysis: The unspoken dialogue. Psychoanalytic Dialogues, 7 (4), 491-516.

Kohut, H. (1971). The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders. New York: International Universities Press, Inc.

Kohut, H. (1977). The restoration of the self. Madison: International Universities Press, Inc.

Kohut, H. (1984). How does analysis cure? A. Goldberg & P. Stepansky (Eds.). Chicago: University of Chicago Press.

Kohut, H., & Wolf, E.S. (1978). The disorders of the self and their treatment: An outline. International Journal of Psychoanalysis, 59, 413-425.

Lachmann, F.M. (2001). Some contributions of empirical infant research to adult psychoanalysis: What have we learned? How can we apply it? Psychoanalytic Dialogues, 11 (2), 167-185.

Lachmann, F.M., & Beebe, B. (1992). Reformulations of early development and transference: Implications for psychic structure formation. In M.N. Eagle, J.W. Barron, & D.L. Wolitzky (Eds.), The interface of psychoanalysis and psychology (pp.133-153). Washington, DC: American Psychological Association.

Lachmann, F.M., & Beebe, B. (1996a). Three Principles of salience in the organisation of the patient-analyst interaction. Psychoanalytic Psychology, 13 (1), 1-22.

Lachmann, F.M., & Beebe, B. (1996b). The contribution of self- and mutual regulation to therapeutic action: A case illustration. In A. Goldberg (Ed.), Progress in self psychology: Vol. 12. Basic ideas reconsidered (pp. 123-140). Hillsdale, NJ: The Analytic Press.

Lee, R.R., & Martin, J.C. (1991). Psychotherapy after Kohut: A textbook of self psychology. Hillsdale, NJ: The Analytic Press.

Lewis, M., & Rosenblum, L. A. (1974). The origins of behavior: Vol. 1. The effect of the infant on its caregiver. New York: John Wiley & Sons.

Lichtenberg, J.D. (1983). Psychoanalysis and infant research. Hillsdale, NJ: The Analytic Press.

Lichtenberg, J.D. (1989). Psychoanalysis and motivation. Hillsdale, NJ: The Analytic Press.

Lindon, J. (1994). Gratification and provision in psychoanalysis: Should we get rid of "the rule of abstinence"? Psychoanalytic Dialogues, 4 (4), 549-582.

Lyons-Ruth, K. (1998). Implicit relational knowing: Its role in development and psychoanalytic treatment. Infant Mental Health Journal, 19 (3), 282-289.

Lyons-Ruth, K. (1999). The two-person unconscious: Intersubjective dialogue, enactive relational representation, and the emergence of new forms of relational organization. Psychoanalytic Inquiry, 19 (4), 576-619.

McMahon, L. (1992). The handbook of play therapy. London: Routledge.

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

Mitchell, S.A., & Black, M.J. (1995). Freud and beyond: A history of modern psychoanalytic thought. New York: Basic Books.

Ogden, T. (1994). Subjects of analysis. Northvale: Jason Aronson Inc.

Orange, D.M., Atwood, G.E., & Stolorow, R.D. (1997). Psychoanalytic inquiry book series: Vol. 17. Working intersubjectively: Contextualism in psychoanalytic practice. Hillsdale, NJ: The Analytic Press.

Pally, R. (2001). A primary role for nonverbal communication in psychoanalysis. Psychoanalytic Inquiry, 21 (1), 71-93.

Priel, B. (1997). Time and self: On the intersubjective construction of time. Psychoanalytic Dialogues, 7 (4), 431-450.

Rustin, J. (1997). Infancy, agency and intersubjectivity: A view of therapeutic action. Psychoanalytic Dialogues, 7 (1), 43-62.

Sander, L.W. (1977) The regulation of exchange in the infant-caretaker system and some aspects of the context-content relationship. The origins of behavior: Vol. 5. Interaction, conversation and the development of language (pp. 133-156). New York: John Wiley & Sons.

Sander, L.W. (1983a) Polarity, paradox, and the organizing process in development. In J.D. Call, E. Galenson, & R.L. Tyson (Eds.), Frontiers of infant psychiatry (pp.333-346). New York: Basic Books, Inc., Publishers.

Sander, L.W. (1983b). To begin with- reflections on ontogeny. In J.D. Lichtenberg & S. Kaplan (Eds.), Reflections on self psychology (pp. 85-104). Hillsdale, NJ: The Analytic Press.

Sander, L.W. (1987) Awareness of inner experience: A systems perspective on self-regulatory process in early development. Child Abuse and Neglect, 11, 339-346.

Schafer, R. (1988). Discussion of panel presentations on psychic structure. Journal of the American Psychoanalytic Association, 36 (suppl.), 295-312.

Seligman, S. (1997). Historical legacies and contemporary innovation. Introduction to symposium on child analysis, Part I. Psychoanalytic Dialogues, 7 (6), 707-723.

Seligman, S. (1998). Child psychoanalysis, adult psychoanalysis, and developmental psychology. Introduction to symposium on child analysis, Part II. Psychoanalytic Dialogues, 8 (1), 79-86.

Seligman, S. (2001). The new baby settles in: Commentary on paper by Frank M. Lachmann. Psychoanalytic Dialogues, 11 (2), 195-211.

Shane, M., & Shane, E. (1996). Self psychology in search of the optimal: A consideration of optimal responsiveness, optimal provision, optimal gratification, and optimal restraint in the

clinical situation. In A. Goldberg (Ed.), Progress in Self Psychology: Vol. 12. Basic Ideas Reconsidered (pp. 37-54). Hillsdale, NJ: The Analytic Press.

Silver, D. (1983). Prologue. In J. D Lichtenberg & S. Kaplan (Eds.), Psychoanalytic inquiry book series: Vol.1. Reflections on self psychology (pp.37-42). Hillsdale, NJ: The Analytic Press.

Silverman, D.K. (1992). Attachment research: An approach to a developmental relational perspective. In N.J. Skolnick & S.C. Warshaw (Eds.), Relational perspectives in psychoanalysis (pp. 195-216). Hillsdale, NJ: The Analytic Press.

Slavin, J.H. (1997). Models of learning and psychoanalytic traditions: Can reform be sustained in psychoanalytic training?. Psychoanalytic Dialogues, 7 (6), 803-817.

Socarides, D. & Stolorow, R. (1984/85). Affects and selfobjects. Annual of Psychoanalysis 12/13, 105-119.

Soref, A.R. (1992). The self in and out of relatedness. The Annual of Psychoanalysis, 20, 25-48.

Sorter, D. (1996). Chase and dodge: An organization of experience. Psychoanalysis and psychotherapy, 13 (1), 68 -75.

Stake, R.E. (1995). The art of case study research. Thousand Oaks: Sage Publications.

St. Clair, M. (1986). Object relations and self psychology: An introduction. Monterey, California: Brooks/Cole Publishing Company.

Stechler, G. (1983). Infancy research: A contribution to self psychology. In J. D Lichtenberg & S. Kaplan (Eds.), Psychoanalytic inquiry book series: Vol.1. Reflections on self psychology (pp.43-48). Hillsdale, NJ: The Analytic Press.

Stechler, G., & Kaplan, S. (1980). The development of the self: A psychoanalytic perspective. The Psychoanalytic Study of the Child, 35, 85-105.

Stern, D.B. (1994). Empathy is interpretation (and who ever said it wasn't?): Commentary on papers by Hayes, Kiersky and Beebe, and Feiner and Kiersky. Psychoanalytic Dialogues, 4 (3), 441-471.

Stern, D.N. (1974). Mother and infant at play: The dyadic interaction involving facial, vocal, and gaze behaviours. In M. Lewis & L.A. Rosenblum (Eds.), The origins of behavior: Vol. 1. The effect of the infant on its caregiver (pp. 187-213). New York: John Wiley & Sons.

Stern, D.N. (1983). The early development of schemas of self, other and "self with other". In J. D Lichtenberg & S. Kaplan (Eds.), Psychoanalytic inquiry book series: Vol.1. Reflections on self psychology (pp.49-84). Hillsdale, NJ: The Analytic Press.

Stern, D.N. (1984). Affect attunement. In J.D. Call, E. Galenson, & R.L. Tyson (Eds.), Frontiers of infant psychiatry, Vol II (pp.3-14). New York: Basic Books, Inc., Publishers.

Stern, D.N. (1985). The interpersonal world of the infant: A view from psychoanalysis and developmental psychology. New York: Basic Books.

Stern, D. N. (1989). The representation of relational patterns: Developmental considerations. In A.J. Sameroff & R.N. Emde (Eds.), Relationship disturbances in early childhood: A developmental approach (pp.52-69). New York: Basic Books, Inc., Publishers.

Stern, D.N. (1994). One way to build a clinically relevant baby. Infant Mental Health Journal, 15 (1), 9-25.

Stern, D. (1998). The process of therapeutic change involving implicit knowledge: some implications of developmental observations for adult psychotherapy. Infant Mental Health Journal, 19 (3), 300-308.

Stolorow, R.D. (1994a). Subjectivity and self psychology. In R.D. Stolorow, G.E. Atwood & B. Brandchaft (Eds.), The Intersubjective Perspective (pp. 31-39). Northvale, NJ: Aronson.

Stolorow, R.D. (1994b). The nature and therapeutic action of psychoanalytic interpretation. In R.D. Stolorow, G.E. Atwood & B. Brandchaft (Eds.), The Intersubjective Perspective (pp. 43-55). Northvale, NJ: Aronson.

Stolorow, R.D & Atwood, G. E. (1992). Psychoanalytic inquiry book series: Vol. 12. Contexts of Being: The intersubjective foundations of psychological life. Hillsdale, NJ: The Analytic Press.

Stolorow, R. & Atwood, G. (1994). Towards a science of human experience. In R.D. Stolorow, G.E. Atwood & B. Brandchaft (Eds.), The Intersubjective Perspective (pp. 15-30). Northvale, NJ: Aronson..

Stolorow, R.D., Brandchaft, B., & Atwood, G.E. (1987). Psychoanalytic inquiry book series: Vol. 8. Psychoanalytic treatment: An intersubjective approach. Hillsdale, NJ: The Analytic Press.

Terman, D.M. (1988). Optimum frustration: Structuralization and the therapeutic process. In A. Goldberg (Ed.), Progress in Self Psychology: Vol. 4. Learning from Kohut (pp. 113-126). Hillsdale, NJ: The Analytic Press.

Thomson, P. (1991). Countertransference in an intersubjective perspective: An experiment. In A. Goldberg (Ed.), Progress in Self Psychology: Vol. 7. The evolution of self psychology (pp. 75-92). Hillsdale, NJ: The Analytic Press.

Tronick, E.Z. (1989). Emotions and emotional communication in infants. American Psychologist, 44 (2), 112-119.

Tronick, E.Z. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. Infant Mental Health Journal, 19 (3), 290-299.

Tronick, E.Z. (2001). Emotional connections and dyadic consciousness in infant-mother and patient-therapist interactions: Commentary on paper by Frank M. Lachmann. Psychoanalytic Dialogues, 11 (2), 187-194.

Tronick, E.Z., & Cohn, J.F. (1989). Infant-mother face-to-face Interaction: Age and gender differences in coordination and the occurrence of miscoordination. Child Development, 60, 85-92.

Warshaw, S.C. (1992). Mutative factors in child psychoanalysis: A comparison of diverse relational perspectives. In N.J. Skolnick & S.C. Warshaw (Eds.), Relational perspectives in psychoanalysis (pp. 147-173). Hillsdale, NJ: The Analytic Press.

Wolf, E. S. (1988). Treating the self: Elements of clinical self psychology. New York: The Guilford Press.

Wolf, E. S. (1989). Therapeutic Experiences. In A. Goldberg (Ed.), Progress in Self Psychology: Vol. 5. Dimensions of Self Experience (pp. 114 -119). Hillsdale, NJ: The Analytic Press.

Yin, R.K. (1994). Case study research: Design and methods (2nd ed.). Thousand Oaks: Sage Publications.

Zeanah, C.H., Anders, T.F., Seifer, R. & Stern, D.N. (1989). Implications of research on infant development for psychodynamic theory and practice. Journal of the American Academy of Child and Adolescent Psychiatry, 28, 657-668.

Zelnick, L., & Buchholz, E.S. (1990). The concept of mental representations in light of recent infant research. Psychoanalytic Psychology, 7 (1), 29-58.