Chapter 3 Self Psychology in Search of the Optimal

A Consideration of Optimal Responsiveness, Optimal Provision, Optimal Gratification, and Optimal Restraint in the Clinical Situation

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Eleven years ago Howard Bacal presented a paper at the Sixth Annual Conference on the Psychology of the Self that proved to be seminal for self psychology and was entitled “Optimal Responsiveness and the Therapeutic Process” (1985). With this paper, and the introduction of a new concept, optimal responsiveness, as well as a new way of viewing the analyst's participation in the therapeutic process, a conversation was begun among us that is still going on. Charles Spezzano (1993) has written, based upon his own application to psychoanalysis of Richard Rorty's (1989) work, that new psychoanalytic concepts appear when we want to discuss certain clinical problems with each other, but we perceive ourselves to be unable to discuss them adequately in the language and conceptual framework familiar and available to us. This has been the history of psychoanalysis from its beginnings. To paraphrase Spezzano, the evolution of psychoanalytic theory is an ongoing conversation, and the exchanges that make up this psychoanalytic conversation are yielding ever more useful clinical concepts. So, here we are now, in this presentation, entering into the conversation about the optimal in the clinician's response. We will focus on guidelines that may help direct us in the search for the appropriate and the useful in the therapeutic moment. We do so with full understanding that any contribution we may make will lead at best to no more than a temporary solution to the clinical problem at hand, or a temporary rest in the dialogue.

The chief participants in this conversation about the optimal in psychoanalysis have included, over time, Sigmund Freud (1911-1915), Anna Freud (1965), Kohut (1971, 1977, 1984), Wolf (1976, 1989), Stolorow, Brandchaft, and Atwood (1987), Bacal (1985), Terman (1988), and, most recently, Lindon (1994). In this chapter, we will focus mainly on the latter three (i.e., Bacal, Terman, and Lindon), who themselves have referenced and amply discussed the important contributions of the others, and we will begin with our own assessment of where the field rests at the present time, and where the conversation has stopped so far.

The impact of Bacal's challenging 1983 presentation was that of calling into question Kohut's generative contribution concerning the role of optimal frustration via transmuting internalization in fostering the structuring and restructuring of the self. As optimal frustration was so central to Kohut's thesis on how analysis cures, the challenge to it had to be made with care and with great persuasiveness, and Bacal was eminently successful in achieving these requirements. In effect, what Bacal accomplished was to demonstrate that Kohut's covert tie to classical analysis hampered his capacity to break free of some hidden assumptions of classical theory. Kohut's accurate observation that clinical work with self-disordered patients is punctuated by disruptions requiring repair, and that following such repair the patient seems improved, was confounded with this sense that it was the frustration itself, requiring that the patient assume functions heretofore supplied by the analyst, that was responsible for the improvement and growth of structure. In contrast, Bacal reasoned that just because structure building followed optimal frustration and its repair, this did not mean that there was an inevitable cause-and-effect relationship between moderate frustration and structure building. Bacal argued that what created new structure was the patient's sense of understanding in itself is therapeutic, that is, leads to psychological growth.

The valorization of frustration had been linked in classical theory to beneficial results because the Freudian model of secondary-process thinking and structure building was related to and depended on the frustration of primary-process drive discharge and gratification (Rapaport, 1960). Although Kohut was able to drop the drive model, he could never relinquish the idea that frustration in itself was beneficial, viewing it as adding to the establishment of what he had originally termed the “narcissistic equilibrium” of the patient, and later, harmony, strength, and cohesiveness of the patient's self.
Bacal was able to persuade many to believe otherwise, leading to the introduction into our clinical vocabulary of the term and concept “optimal responsiveness” and, as well, to a set of new questions regarding what it means to be “responsive,” and especially what is meant by “optimal.” Noting that Kohut himself had posed the question about what is optimal in optimal frustration, but had never arrived at a satisfactory answer, Bacal, describing “responsiveness” as the therapist's act of communicating his understanding of the patient to the patient, then defines the “optimal” as that response which for that particular patient will be most suited to the patient's developmental capacity and selfobject needs for human relatedness. Further, optimal responsiveness was presented by Bacal as the umbrella term that would subsume optimal frustration, gratification, and provision. Bacal noted that whereas frustration and gratification are both inevitable in the clinical relationship, neither serves as an appropriate treatment goal for the analyst; the analyst should neither seek to deliberately frustrate, however optimally, nor seek to deliberately gratify. Rather, the proper goal in the clinical situation is that the analyst, having understood his or her patient, should then communicate that understanding through an optimal response.

Bacal offers to the analyst two guidelines toward the optimal response. The first derives from Kohut's concept of a developmental line of empathy, an advance from understanding to interpretation to be offered by the analyst in response to a progression the analyst has observed in the patient from an earlier, more archaic form of capacity to feel the analyst's empathy, in which a literal holding environment or an experience of merger is required with the analyst, to a more evolved form of capacity to feel the analyst's empathy, where a more metaphorical holding environment provided through verbal understanding or explanation is now adequate to serve the patient's selfobject needs. Kohut had illustrated this progression by speaking of the young child's needing bodily contact, and then the child's developing to a capacity wherein words alone could achieve the same result. This was translated into the clinical realm by Kohut in his famous and final demonstration of empathy with a severely disturbed patient to whom he offered his hand, (or, more accurately, a restrained two fingers), and also in the distinction he made between the understanding phase of interpretation and the explaining phase. Thus the developmental line of empathy serves as the first guideline offered by Bacal for optimal responsiveness. The second guideline he offers toward optimal responsiveness also derives from Kohut's writings—the state of self—selfobject relatedness along a continuum of disruption and repair. When the patient is in a disrupted state, and the self—selfobject relationship is at an impasse, a different sort of response is called for from the analyst than when the selfobject tie has either been restituted or is perceived as smoothly ongoing.

With this comprehensive, indeed groundbreaking, statement, it is interesting to note that the conversation about the optimal did not rest there. Three years after Bacal's paper was presented, Terman appeared at the Eighth Annual Conference on the Psychology of the Self (1986) to address the audience on “Optimal Frustration: Structuralization and the Therapeutic Process.” Terman's paper proved to be a useful addition to Bacal's original thesis, providing more than just supporting evidence for it. Terman's own opposition to Kohut's concept of optimal frustration derives primarily from two sources. The first source is evidence from his psychoanalytic practice, which to him clearly did not conform to Kohut's theory of structure building via optimal frustration and transmuting internalization, but instead convinced him that in the clinical situation, understanding of the old and creation of the new had nothing to do with the experience of frustration; rather, it was the experience of satisfaction that opened new pathways for the patient and remade old ones. The second source for Terman's opposition was drawn by him from developmental studies, the findings from which preclude the concept that structures can arise or develop from absence in the dyad, or interruption of the dyad, as would seem to be inherent in a frustration model of development. On the contrary, findings from developmental studies emphasize that structuralization of the mind grows only out of the presence of human relationships, not apart from them.

Terman cites the developmentalist Kenneth Kaye, who stresses the two-way process of creating and structuring the infant's mind, the parent continuously drawing the child forward in the dyad, in the zone of proximal development, eventually toward a full partnership. Terman also refers to Daniel Stern to demonstrate that it is the repetition and participation of the caretaker in the child's activities, not the absence of the caretaker, that lays down governing patterns. To quote Terman (1988), “The shaping, molding, and structuring of internal states … occurs by way of the vicissitudes of attunement” (p. 125), not by way of frustration.

Terman's point again is that frustration does not build structure, and he refers to Socarides and Stolorow, who contend that it is the intactness of the selfobject tie that permits the resumption of development, not its disruption following frustration.

Supportive of Bacal's position, then, Terman actually goes beyond him with an important addition to our understanding to how structure is formed, both in development and in the clinical situation. Terman argues that the concept of frustration leading to structure has distracted us from the variety of transactions between caretaker and child and between analyst and
cannot be encompassed by a "rule," such as had existed in the rule of abstinence, but must be approached instead by what is enactment that obstructs the enactments are recounted, Lindon warning that provision may become subverted to addiction in a process of mutual Lindon provides a sense of what he means by "optimal" and certainly what he means by "provision." Countertransference developmental longing, facilitates the uncovering, illuminating, and transforming of the subjective experiences of the patient." "Optimal provision," Lindon optimal for the particular patient. This inevitably leads back to the central question, What is optimal in optimal provision? Respond with optimal himself was acting independently, unaware of Bacal's and Terman's earlier contributions. rich and openly presented paper containing illustrations of both interpretive and noninterpretive interventions, though Lindon invitation, then, to discuss openly, without fear, noninterpretive optimal responsiveness was addressed by Linden's clinically himself was acting independently, unaware of Bacal's and Terman's earlier contributions. Linden's particular emphasis is on the rule of abstinence, which he contends is both pantheoretical and universally obstructionistic to the unfolding of the analytic process. He asserts that the analyst, rather than having a withholding, frustrating stance designed to enhance the patient's verbalization and ultimate insight through interpretation, should instead tailor his or her response to the patient's requirements. To perceived developmental needs on the part of the patient, the analyst should respond with optimal provision; to perceived urgent desires on the part of the patient, the analyst should respond with optimal gratification. Although gratification and provision exist in every analytic relationship, these concepts cannot be encompassed by a "rule," such as had existed in the rule of abstinence, but must be approached instead by what is optimal for the particular patient. This inevitably leads back to the central question, What is optimal in optimal provision? "Optimal provision," Lindon (1994) tells us, "could be defined as any provision which, by meeting a mobilized developmental longing, facilitates the uncovering, illuminating, and transforming of the subjective experiences of the patient" (p. 559), a definition informed by Stolorow, and Atwood's (1984) own definition of psychoanalysis, namely, a process that aims at uncovering, illuminating, and transforming the patient's organizing principles. By offering many clinical illustrations, Lindon provides a sense of what he means by "optimal" and certainly what he means by "provision." Countertransference enactments are recounted, Lindon warning that provision may become subverted to addiction in a process of mutual enactment that obstructs the analytic process.

At this point we would like to enter into the conversation more directly, hoping to further an understanding of the optimal in the therapeutic dyad. We are persuaded by Bacal that optimal responsiveness, defined by him as the responsibility of the analyst that is therapeutically most relevant at any particular moment in the context of a particular patient and his or her pathology, does accurately identify the therapeutic goal of the clinician, that the clinician does not seek to frustrate, nor even to gratify, but to respond in such a fashion as to communicate to the patient that he or she has been understood, in both direct (interpretive) and indirect (noninterpretive) ways. We believe that the capacity for optimal responsiveness comes through empathy and affect attunement, but the guiding principle is informed by one's particular theory of development and pathology as it applies to a specific patient. From our own perspective, the other familiar terms traditionally used to guide the therapist's intervention are subsumed under optimal
responsiveness, including Linden's optimal provision (the response to the patient's *need*) and optimal gratification (the response to the patient's *desire*).

We would, along with Lindon, eliminate the rule of abstinence, but we would in fact go further, replacing the term altogether, since it connotes an absence, or shutting down of response. Still, we believe there is some need for reserve, so we would offer the term “optimal restraint” as supplying that function, that is, a response within the therapeutic dyad that is neither in excess of what is needed or desired by the patient, nor so withholding or so unspontaneous that it serves to derail the process. As with provision, restraint should be tailored, insofar as possible, to the clinical moment with the particular patient, ideally negotiated and co-constructed by both participants. As for optimal frustration, we are in agreement with the tenor of the conversation thus far that the concept of optimal frustration is a relic of the past, that while the patient may at times be frustrated, this is not an appropriate or desirable treatment goal for the therapist to have. We feel this altered view of the process has profound meaning for how all analyses will be understood in the future, allowing us not only to *proceed* differently, but to *reflect* differently on the analyses we have already completed.

We would like to devote the remainder of our presentation to a further consideration of guidelines toward optimal responsivity in the analytic situation. We will begin with a brief discussion of our own perspective on clinical self-psychological theory as our view of clinical theory introduces one important guideline toward the optimal.

As we have stated elsewhere (1992), self psychology as a single homogenous entity does not exist; there are now many self psychologies. We ourselves integrate current self-psychological theory with inter-subjectivity, in an effort to modify the direction of self psychology toward a more truly relational developmental perspective. We strive to establish an ambiance of safety so that the patient may gradually risk exposing his or her conscious and preconscious private world. Eventually, defenses against uncovering what is feared, sequestered, and repressed are interpreted in their present here-and-now manifestation, in the transference, and in their genetic roots. The whole process, the messenger and the message (Schlesinger, 1988), is viewed by us as constituting the therapeutic action, in a contemporary mode of corrective emotional experience. Although we retain as singularly important the idea of selfobject relatedness, equating it more or less with Stern's core self in relation to a self-regulating other, we don't believe that the selfobject concept is sufficient to explain all types of relatedness either in development or in the clinical situation, and we don't find either that the concept of mature, as distinct from archaic, selfobject relatedness answers our concern. We find it essential to postulate as well another dimension of relatedness, an intersubjective relatedness, that encompasses a subjective self in relation to an intersubjective other wherein each subject in the dyad can appreciate the other as a person in his or her own right, each possessing a separate and distinct mind and set of motives, intentions, and emotions, not all of them positive, leading in the direction of a mutuality and intimacy between two subjectivities. In Stern's (1994) terms, it is the interactive state of “I know that you know that I know” and “I feel that you feel that I feel,” and most importantly, we would add, “I care to know and feel all about us, about you, about me, and about our ‘weness’” (Emde, 1988).

Although we appreciate and borrow freely from the contributions of Stolorow, Brandchaft, and Atwood to self psychology, in particular their concept of intersubjectivity as defining the mutual influence of each person upon the other in the intersubjective matrix between them, as well as their concept of unconscious (sequestered) organizing principles in both patient and analyst, requiring the analyst's articulation and interpretation, our difference with them is that we view the concept of intersubjectivity in a less global fashion, reserving the capacity to interact in an intersubjective fashion to a relationship wherein each member in the dyad is concerned with the otherness, the subjectivity of the other. By maintaining this distinction, we can better conceptualize and delineate the quality of selfobject relatedness from the more mature capacity for a self—other relatedness wherein the other is appreciated as a person in his or her own right.

We conceptualize, then, only the dimension of experience that corresponds to the subjective self and the intersubjective other as truly intersubjective, in that in such a case, each person in the dyad is vitally interested in the subjectivity of the other. In contrast, the patient who is relating to his or her analyst in the selfobject dimension is not relating to his or her analyst as a subjective entity, but, in selfobject terms, is relating to the analyst as a provider of functions, or experiences a requisite for self-sustenance, with little or no involvement in the other's complex inner world and little or no capacity for, or interest in, mutuality or inter-subjective intimacy. In the clinical situation, the selfobject dimension of relatedness is distinctly one-sided; the analysis, ideally, fully concerned with the intrapsychic world of the patient via empathy, as well as being concerned with his or her own intrapsychic world, and the intersubjectivity between himself and his patient, whereas the patient uses the relationship in a more one-sided way, via selfobject functions. We want to clarify that this more focused view of intersubjectivity inherent in our clinical theory is not meant to detract from what Stolorow, Brandchaft, and Atwood have
told us about the significant impact of each member of the dyad on the subjective experience of the other; this important insight remains valid whether that other, the analyst, is experienced by the patient in the intersubjective or in the selfobject dimension.

One pathway to optimal responsiveness, then, stems from the therapist's attention to which dimension of relatedness is in the foreground at any point in the analysis. For example, a young woman who suffered from a development impairment wherein she could, in effect, only relate to others as archaic selfobjects complained bitterly to her analyst one day about a good friend's slighting her by canceling a small dinner the woman had been planning to celebrate the patient's birthday. The patient had been depending on the dinner to ameliorate her sense of being alone, and was now faced with the prospect of being deserted on her birthday. The depth of her pain, genuine and understandable, was the center of her focus, and it was only in passing that she noted to her analyst the reason for the cancellation, that the friend was pregnant, having struggled for years to achieve this, and was now at risk of losing her child and was ordered by her physician to remain at bed rest. The patient could talk about this situation and note her own reluctance to commiserate with her friend's grief, which she understood intellectually, but not emotionally. She said, “I tell her everything about myself, and I always expect her to feel for me, but I cannot and I am not interested in, hearing about or feeling for her.” The patient, then, was able on her own to see the irony of the situation, the lack of symmetry in the relationships she establishes. Her analyst responded to her with an affirmation of her feelings but without any attempt to interpret the patient's discomfort with her own perception of this imbalance. The analyst did not confront her with her developmental incapacity, interpret its origins, or in any way bring it into the transference, to the analyst's own experiences of being similarly unresponded to and unappreciated by this patient; in other words, a garden variety self-psychological response was offered by the analyst, informed by knowledge of this patient's archaic selfobject neediness.

Our point is that optimal responsiveness for this patient would require taking into consideration the dimension of relatedness currently at the forefront of her experience. In contrast, in another analytic dyad, a depressed female patient whose parents have been unhappy with one another, and distant and controlling with her, comments to her male analyst, who is in supervision with one of us, that she knows he is subtly but distinctly interested in her, both as a person, and more pertinently, as a sexually desirable woman. She also tells him that she feels he is unhappy in his own personal life, and that she knows she adds with her presence in his life some essential vitality and interest to his existence. As it happens, the patient's perceptions are absolutely correct on all counts, including her assertions about her analyst's sexual interest in her, and at times, even his sexual excitement. Moreover, the patient tells her analyst that she feels sorry for him, that she wishes to comfort him, knows that he really desires her comfort, and would like a romantic involvement with her, but that both understand that such an affair is out of the question.

On his side, the analyst knows that she knows all of this, he appreciates her for it, feels a poignancy in the intimacy of their relationship, and is able to use all of this to respond in a respectful, insightful way that does not deny her reality, and yet shows optimal restraint. This analyst could have interpreted his patient's sense of his own unhappiness as transference, a displacement from her own parent's troubled marriage, but chooses more authentically and more optimally to stay with her in the here and now, despite his own discomfort at being so exposed, cognizant of this patient's capacity to relate on a fully intersubjective level and resonate accurately with his self state. Aware that he is hewing a fine line between optimal and nonoptimal, even dangerous, responsiveness, he proceeds nevertheless to explore her experience of him, never denying her reality and perceptiveness, and knowing that such risks constitute the occupational hazard of all well-functioning, self-attuned, self-reflective analysts. This analyst was appreciative also of this patient's selfobject needs which indeed have come to the fore many times; he was appreciative that his patient's capacity for reading his subjectivity was derived from the necessity throughout her childhood of being aware of and alert to her parent's fluctuating and sometimes dangerous moods. Nevertheless, he did not mistake this particular instance of intersubjective mutuality for a simple, unconscious genetic recreation, nor for a need on her part for a one-sided provision of self-regulating functions. It is our contention, then, that both dimensions of relatedness must be kept in mind as guidelines to the quality of optimal responsivity, as well as what is subsumed under this umbrella term (viz., optimal provision, gratification, and restraint).

Another guideline in our search for the optimal is attention to a comprehensive organization of motivational systems, such as the one first Lichtenberg (1989) and now Lichtenberg, Lachmann, and Fosshage (1992) delineate. By detecting in a given patient precisely what motive is most prevalent in the therapeutic moment, we can come closer to identifying the “main meaning,” to use Lawrence Friedman's (1996) apt phrase, and with that understanding, respond most optimally. For example, an anorexic bulimic patient who has severe problems in regulating her physiological need states, particularly her eating and defecating, works together with her analyst in a way that highlights the patient's physiological deregulation. The analyst does not translate her patient's difficulty into classical dynamic motivational formulations such as forbidden oedipal wishes to bear
a child, or oral aggressive wishes to destroy a hated mother within, trends that could certainly be found, if one seeks them, sifting through what the patient brings in. Nor does the analyst address the problem in the attachment realm, though this longing, too, can be discerned quite easily in the patient's association. Rather, the analyst goes directly to the patient's urgent inability to deal with the psychological effects of her chronic eating and bowel disregulation, which inability is analyzed both within present and past disturbed relationships, especially the relationship with her mother, her thin and beautiful mother who always felt that the patient was too fat.

The analyst will deliberately inquire as to how and what the patient eats, both in her periods of bulimia and in her periods of anorexia. She actually shares with her patient information about what she herself eats, and how she herself attempts to maintain her own weight and health. The analyst continues to focus on this motivational system irrespective of its more or less obvious connections to other motivational systems more salient in the analytic literature. She abides her own discomfort at not acting like a real analyst, because she has detected that the main meaning in this patient's disturbed relatedness is encompassed in this motivational-functional system. She therefore relates to the patient directly in this dimension, in order to respond optimally, using provision, in Linden's sense (i.e., dietary direction, shared nutritional needs, and the like) and, again in Linden's sense, gratification (i.e., self-revelation of her own private battle in the same arena so as to provide a sense that the patient is not alone in the difficulty, but shares it with her much-admired, idealized analyst). By recognizing multiple motivational systems, then, the therapist has a greater chance of responding most precisely to the patient's predicament.

An example follows wherein the main meaning for the patient is found in the attachment-motivational system. This foreground need was confounded because for the analyst, a confused state of feeling sexual stimulation, and then guilt and shame over it, interfered for a time with his capacity to respond optimally. Some years ago a woman patient was in the middle of an analysis that had gone on for five years when she developed an eye pathology that led over the next year to marked diminution in her vision, and ultimately blindness. Understandably distressed, the patient in time requested that the analyst hold her hand while she was lying on the couch, at least at the beginning of each hour, and that upon leaving, she be allowed to stroke his arm for some moments, and at times to feel his face. These requests appeared quite understandable in view of the patient's need to augment the perception of her analyst and her vital attachment to him through touch, but the analyst, who was overly rigorous in regard to allowing any physical contact with patients, or to put it more simply, was upright, found himself, while without question acceding to his patient's request, in a state of discomfort; he unavoidably and involuntarily experienced his interaction with his patient, when either holding her hand or being stroked by her, as sexually charged. This dissonance within himself had to be resolved as quickly as possible in order to allow him to be optimally responsive to his patient, to be, that is, attuned and available to his patient's need for special provision in the attachment sphere, which is where she was.

As he came to be able to respond more authentically to her touch, with a less divided internal state, the analyst was then also able to reflect upon his exceeding rigor, his need to do the right thing and be the proper analyst, and he was able as well to look back on previous experiences with patients in which he might have been more optimally responsive in this same way. The change in him was facilitated in part by an appreciation of the fact that the attachment-motivational system was separate from, not derivative of, the sensual-sexual system as he had originally been taught. Were the main meaning of the patient's desire for physical contact within the sensual-sexual sphere, then the analyst, to respond optimally, might still have acceded to this blind patient's request, but he would have pursued the inquiry into its main meaning for the patient in a different direction. Thus, detecting as closely as possible the salient motive in the clinical moment facilitates an understanding of the most helpful way to be with and respond to a given patient.

As a final example of the use of motivational systems to aid in the achievement of optimal responsiveness, we will provide an instance derived from the assertive-exploratory mode. The analyst greets her patient in the waiting room and is struck by the beauty of the patient's jacket, which is lying on the chair next to where the patient was sitting. The analyst spontaneously remarks about it, commenting on the lushness of color, and they enter the office together talking of other things.

At the end of the session, which was filled with the patient's emotion concerning her relationship with her inadequately responsive mother and who had died when the patient was 21, the patient and analyst get up together. The patient lifts her jacket from the couch and quite suddenly extends her arm, saying, “Here. You admire this, I really don't, and I want you to have it.” The analyst, nonplussed, completely taken off guard, and striving to remain an analyst with an appropriate degree of optimal restraint, after first spontaneously reaching out to take it from the patient's hand, and noting, without wanting to, the pure pleasure of its expensive silken feel, again just as spontaneously returns it to her patient, saying, “I simply can't just take your jacket; let's talk about it tomorrow.”
The next day the patient returns furious, ready and fully energized to explore the encounter with her analyst. She jumps right in with the following statement: “How can you be so stupid and unfeeling? You of all people know how hard it is for me to feel I have anything of worth to offer. You know how hard it is for me to take a chance and do something risky and experimental. You know how hard it is for me to assert myself at all. And yet you humiliate me by rebuffing my offer of something which belongs to me, and which you like. I can only think it is because it is mine that it is distasteful to you, and I feel ashamed, and angry with you that you caused me to feel this way.” At this point, the analyst feels remorseful, confused, disturbed, and humiliated herself. Now she is truly uncertain as to what to do, and uncertain also about what she should have done the day before. Groping and slouching toward the optimal, she responds by telling her patient that the patient's offer was only made, after all, in response to the analyst herself having admired it, that it was not something the patient would otherwise have intended to give her, and it wasn't as if it were a gift she had brought in with the full expectation of presenting it. She also tells the patient that she feels remorse for how she had handled the situation up till now, that certainly she had no intention of squelching the patient's experimental mood, and that, in fact, the analyst's response was based on her own awkwardness, her own sense of being thrown off balance. By these statements the analyst had intended to support the patient's new and tentative effort to assert herself.

And the analyst's remarks did seem to repair the moderate impasse, for the next day the patient, exhibiting a new resourcefulness and a fine sensitivity and irony, ceremoniously presented her analyst with the jacket in an elaborately gift-wrapped box. The analyst this time acted with more grace, both to the gift and to the joyful and humorous spirit with which it was offered. Over the weeks that followed, the incident was considered in terms of the many meanings, conscious and unconscious,

... of this mutual enactment for both parties. The ongoing analysis of the event is not relevant to our discussion here, except to say that it left the pair somehow more closely connected and more at ease with one another.

We will turn now to a consideration of guidelines toward the optimal response inherent in specific diagnostic categories as recognized by various self-psychological contributors. The work of Basch (1988) concerns the clinician's determination as to how affect is subjectively perceived and integrated, or not integrated, in a given patient. The manner in which affect is perceived and integrated is conceptualized by Basch as contributing to the development of different pathological states; in his system, the pathological state itself serves as a guideline to the therapist's most appropriate and useful response. For example, Basch has identified pathological self-states resulting from an initial failure of the affective bond between the infant or very young child and its caregivers, wherein the normal mutual regulation and self-regulation of affect is interfered with, requiring from the clinician a specific type of responsiveness, namely, one that enhances the patient's capacity to soothe and regulated, as well as to self-soothe and self-regulate. For example, a patient who has had a history of maternal deprivation begins treatment with her therapist by coming in so late to each scheduled session that only five or ten minutes remain. The therapist responds initially by just accepting her lateness, and using what is left of their time together for attempting to deal with her anxiety, which increases predictably during the session—increasing, that is, as the session progresses. This pattern leads the therapist to deduce that the patient's lateness is a function of the degree to which being with him causes her unbearable stimulation, so that she, either consciously or unconsciously, titrates the time with him and thereby self-regulates her anxiety within the therapeutic matrix. The strategy of not interpreting the lateness, or even questioning it, works, because the patient feels increasingly comfortable with her therapist and can then allow herself to spend more of the allotted time with him, arriving less late as the therapy progresses. This exemplifies the need, with patients who have suffered from a significant failure in the affective bond, for the therapist to attend first and foremost to that patient's need for soothing and regulation.

Basch has also identified self states that result from failures of the caregiver to attune to and name for the child particular affect states, leaving the individual unable to identify feelings and emotions, and requiring of the clinician that he or she empathically sort out and name these feelings and emotions for and with the patient as the optimal response. Basch asserts that such pathological self states are not usefully addressed through affirmation, that specific response should be reserved for the patient who recognizes his or her affect states, but feels shame in relation to them.

Whereas Basch particularizes in this way individuals who suffer from pathological affect states and the response from the therapist that is most optimal, Stolorow and his colleagues write more inclusively about affect integration, which entails conditions wherein affect is rendered inaccessible to the individual, offering to the therapist an approach encompassing close attention to and empathy with the patient's feeling states as they manifest and shift in the transference.

And for another brief example of the use of diagnostic categories as guidelines toward the optimal, Goldberg (1995) offers a comprehensive approach to the treatment of perversions. His understanding of the pathology involved leads him to address an interpretive mending of the vertical split viewed by him as etiologically significant in these narcissistic behavior
disorders. Thus, the guideline to the optimal response offered by Goldberg is to actively interpret aspects of the vertical split, especially within the transference.

We will turn now to a final guideline toward the optimal, which is to be found in an important contribution by Beebe and Lachmann (1994) entitled “The Three Principles of Salience” and which concerns how structure is developed, or how an infant learns in the normal parent—child relationship. The three principles of salience describe interaction structures in the first year of life, and include the familiar concept of disruption and repair, and the concept of heightened affective moments. But the most salient of these three avenues toward structure building observed in the infant—caregiver dyad is that of ongoing regulations, a concept developed by Beebe and Lachmann, which serves as the most overarching of these three principles. The ongoing regulations construct captures the characteristic patterns of repeated interactions, the patterns of mutual regulation and self-regulation that the infant comes to recognize and expect. This going-on-being in the infant—caregiver dyad is characterized not by dramatic moments, either disruptive or epiphenomenal, but by the quiet, uneventful experiences of well-being in the relationship that have largely escaped attention because of their background quality. It's interesting in this context that in an earlier presentation of this chapter, a fourth principle of salience was noted, that of the familiar frustration-gratification sequence, but the authors ultimately decided that these experiences were secondary to the other three principles noted here. This conclusion, drawn from the arena of infant and child observation, confirms the clinical sense of all the contributors to the conversation about optimal responsiveness considered here: frustration is not a useful guide for the clinician as a method of enhancing development progression and structure building.

We believe that a conclusion can be drawn from this convergence of clinical and observational data; not only is the clinical importance of frustration as a vehicle for meliorative change diminished, as we have just said, but more than this, the significance of continuity in the analytic dyad is confirmed. Being safe and in-sync with one's caregivers, whether in childhood or in analysis, is important both for normal development and for therapeutic change. It would seem that if these findings from the clinical situation and the laboratory are taken seriously, one will see more reports in the literature than currently exist wherein analysis is described with less attention to disruptions that frustrate and dismay the patient, but which do make the analyst feel that he or she is truly doing analysis. If our theory doesn't focus especially on frustration and impasse, perhaps our clinical work, both as experienced and as reported, will take on a different look. We think of analyses we ourselves have conducted that are characterized by a minimum of disruption and impasse, and that have seemed to us, at moments of uncertainty and self-doubt, for that very reason, to be inadequate, incomplete, and insufficiently deep, even though the therapeutic results appear to be as good, or even better, than analyses that look like the picture a theory of optimal frustration would seem to dictate.

For example, a patient in the field, finishing seven years of a successful training analysis—successful, that is, by any measure of symptomatic and character improvement and conflict resolution—tells his analyst that he cannot help but feel that something must have been missing, that both he and the analyst must have overlooked deeply buried conflicts of aggression, murder, envy, and the like. The patient would be concerned about this from time to time during the analysis, too, whenever he would compare his own analytic experience with certain of his contemporaries, and especially, when he would be taught by analysts who had a particular dramatic flair for the “deep”; the analyst himself, in response, could not help but wonder whether this might have some validity. But try as they may, the pair could do no more than work together in a general atmosphere of calm, cooperation, and friendly feeling, despite occasional misunderstandings and disruptions. Then there is another analytic pair who are currently completing eight years of analysis wherein the work is characterized throughout by a similar continuity, smooth developmental progression, and articulation of an increasingly illuminated life narrative. In this instance the patient doesn't have any doubts about the value and depth of her analysis, but then, the patient is not in the field. The analyst, however, does worry at times that something must have been missed or overlooked—it seems on the whole to be too simple, too easy, and too pleasant an experience to be real—a conclusion can be drawn from this convergence of clinical and observational data; not only is the clinical importance of frustration as a vehicle for meliorative change diminished, as we have just said, but more than this, the significance of continuity in the analytic dyad is confirmed. Being safe and in-sync with one's caregivers, whether in childhood or in analysis, is important both for normal development and for therapeutic change. It would seem that if these findings from the clinical situation and the laboratory are taken seriously, one will see more reports in the literature than currently exist wherein analysis is described with less attention to disruptions that frustrate and dismay the patient, but which do make the analyst feel that he or she is truly doing analysis. If our theory doesn't focus especially on frustration and impasse, perhaps our clinical work, both as experienced and as reported, will take on a different look. We think of analyses we ourselves have conducted that are characterized by a minimum of disruption and impasse, and that have seemed to us, at moments of uncertainty and self-doubt, for that very reason, to be inadequate, incomplete, and insufficiently deep, even though the therapeutic results appear to be as good, or even better, than analyses that look like the picture a theory of optimal frustration would seem to dictate.

We wonder if the result of this entire contemporary psychoanalytic conversation about the optimal response might be to relax self psychologists even further, in concert with Kohut's observations about the relative ease with which the self psychologist does his or her work (1984). But we would like to close on a note of some discomfort: The notion of a pursuit of the optimal is itself, perhaps, too optimistic (the words share the same Latin root), and possibly somewhat dangerous for that reason. Though optimism is essential, it carries with it the hidden and mistaken confidence that one should seek for perfection, that one can actually discover the just-right response for every patient in every situation.

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