Empirical infant research can expand our understanding of therapeutic action in adult treatment. Our primary concern, however, is not dynamic content or reconstructions of early development, but rather organizing principles of interactions. In presenting the case of Karen, we build on our systems view that self- and interactive regulation are simultaneous, complementary, and optimally in dynamic balance. For Karen, the system was out of balance, drastically tilted toward self-regulation. Sander's (1977, 1995) view that inner experience is organized in the interactive context provided a guide for the treatment. By analogy to Sander, the patient–analyst system can construct a unique facilitation of, or constraint on, the patient's access to and awareness of inner states and the patient's experience of agency with regard to inner states. We use the case of Karen to illustrate both the origins and the transformations of her psychopathology. Chronically mismatched interactive regulations led her to premature, drastic self-regulations. We trace the interactive reorganization of self-regulation as the primary theme of therapeutic action.
Chapter 3

The model of development derived from infant research cannot, of course, be directly translated into the adult psychoanalytic situation. In adults, the capacity for symbolization and the subjective elaboration of experience in the form of fantasies, wishes, and defenses, further modify the organization and representation of interactive and self-regulation patterns. What makes this model appealing for adult treatment, however, is that it makes no assumptions about the dynamic content of adult experience. It focuses entirely on the process of interactive regulation.

The ability to respond and be socially engaged depends not only on the nature of the partner's input, and on one's own responsivity, but also on the regulation of the internal state of both participants (Beebe and Lachmann, 1994). The word state is used broadly to refer to affect, arousal, and the symbolic elaboration of state. From infancy onward, people differ in the crucial capacity to modulate arousal, shift state, and tolerate and use stimulation to organize behavior in predictable ways (Korner and Grostein, 1976; Als and Brazelton, 1981).

Specific failures in self-regulation affect the quality of interactive regulation. For example, infants with specific self-regulatory difficulties may place undue burdens on the responsivity of their partners. Whether derived from variations in individual endowment or failures in interactive regulation, difficulties in self-regulation affect the quality of engagement.

Likewise, specific failures in interactive regulation may compromise self-regulation. For example, as in the case discussed in this chapter, affect regulation (Socrates and Stolorow, 1984/85), anxiety, tension, and aloneness (Adler and Buie, 1979) may then be relegated to solitary measures, without a sense of support. Expectations of being abandoned when one is vulnerable may be organized rather than a growing self-reliance and self-sufficiency, aversions, anxieties about relationships, or self-protective depersonalization may ensue.

Our integration is designed not to supplant dynamic formulations but, rather, to provide the analyst with a more differentiated view of the regulation of interactions and the organization of experience that goes beyond interpretation. We are not proposing a new technique, nor arguing for decreased attention to dynamic issues in treatment. Instead, we are reversing the figure-ground perspective customarily used in describing analytic treatment. We are placing the mutually regulated nonverbal exchanges into the foreground. Dynamic conceptualizations are in the background.

Many well-established psychoanalytic concepts already cover some of the same terrain as self- and interactive regulation. For example, ongoing regulations have been subsumed within discussions of patterns of transference and countertransference, the "homing environment" (Winnicott, 1965), and the "background of safety" (Sandler, 1987). The nonverbal interactions on which we focus have been included among noninterpretive analytic behaviors (for example, Freud, 1909; Ferenczi, 1930; Lindon, 1994). These interventions have been made when words were considered to be inadequate to retain a therapeutic connection with certain patients. We hold, however, that nonverbal interactions, like noninterpretive actions, do constitute interpretive activity, although they are not packaged in the customary form. Their intent is to provide a primary contribution to the patient's expectation of being understood.

Although the self- and interactive regulation of nonverbal exchanges is relevant to all treatments, attention to this dimension becomes particularly critical in contacting "difficult-to-reach" patients for whom the essential cues go far beyond the usual verbal exchange.

The treatment of Karen emphasizes the analyst's and the patient's interactions of affect, mood, arousal, and rhythm. We track interactions at the microlevel of rhythm matching, modulation of vocal contour, pausing, postural matching, and gaze patterns. We describe the ways in which these interactions powerfully affected the joint construction of the psychoanalytic relationship. Alterations in the self-regulatory ranges of both patient and analyst ensued.

The Case of Karen

Karen (treated by Frank Lachmann) began psychoanalytic therapy after her first suicide attempt. When her then-boyfriend flirted with another woman, she took all the pills in her medicine cabinet. Like an automaton, she watched her actions "from a bird's eye view from
recognize her tentative attempt to reach out to me. Overtly, Karen hardly acknowledged my presence, although her opening question, "What shall we talk about?" did contain a "we."

Gradually, I came to appreciate that Karen dreaded conversing with me. She anticipated that she would have difficult feelings that she would have to regulate on her own. This expectation suggests an imbalance between self- and interactive regulation in her development. By analogy to the work of Tronick (1989) on depressed mothers and their infants, in the context of chronic interactive mis-regulation, a preoccupation with self-regulation and the management of negative affect on one's own can develop. For Karen, despite her preoccupation with self-regulation, her self-regulatory efforts were severely impaired. Her sleep disturbance, listless state, and lack of "desire" and dissociated episodes were evidence of this impaired regulation of affect and arousal.

What self-regulatory range did Karen bring to treatment? A narrow range of tolerable affect, arousal, and engagement; an immobile face; a tendency to "space out;" and massive efforts to dampen down her reactivity to all stimulation. In sessions she looked out of my office window as she sat in her chair with her coat on. When she did look at me, it was with a sideways glance. Interactions with Karen were dominated by her withdrawal.

Slowly Karen began to reveal her experiences in her family. From the age of five on, she had been awakened during the night by her parents' fights. She could hear their shouts through the walls of her bedroom. Her mother would accuse her father of staying out at night with other women, and her father would, at times, be physically abusive toward her mother. The fights terrified her, especially after her mother asked her who she would want to go with if she and her father separated. She remembered not wanting to go with either one. They never did separate.

Karen was born shortly after her parents' graduation from high school. Neither parent hid from Karen that their future plans had been scuttled by their marriage and her birth. In reaction, Karen began to pray at night. By the time she was seven, she had made a deal with God. If He would stop her parents from fighting, she
would give up her life. From that time forward she was preoccupied with suicide and suffered from severe, persistent sleep disturbances.

In high school, Karen frequently cut classes because she could not tolerate the noise made by other students. Sometimes she would get as far as the classroom door, stand outside, but be unable to enter. She would then go home and spend the day studying alone. She did appear for examinations, on which she did very well. During afternoons and evenings she worked as a cashier at a local shopping mall. In fact, she worked continuously until the end of her high school years. Since then and until her treatment was well under way, she had not held a job.

By the age of 17, Karen had formed an intimate sustaining relationship with a fellow student, Brian. He was her best friend and confidant. When he unexpectedly died of a brain tumor, she was despondent. Her parents insisted that she get over her loss quickly. They could not understand that Karen had lost the one person to whom she felt close and whom she trusted. She retreated to her room, felt “without desires,” and became increasingly aimless. This was not the first time she had experienced these states. At prior times they were more or less transient. At this point they crystallized as a recurring dominant state.

When Karen began therapy, 10 years later, these states were still prominent and affected the nature of our interaction. Though we sat facing each other, Karen looked away from me. Her face was immobile. Her voice had no contouring. Even when I spoke to her she did not look at me. Her self-constriction powerfully affected me. I felt reluctant to jar her precariously maintained presentation.

I responded to her constriction by partially constricting myself. I allowed myself to be influenced by her rhythm. I narrowed my own expansiveness to match more closely the limits imposed by her own narrow affective range. I did look at her continually, but I kept my voice even and soft. In my initial comments I remained within the limits of the concrete details that she offered. I thus altered the regulation of my own arousal, keeping it low and limiting my customary expansiveness. She was effective in communicating her dis-

tress, and I was able to respond by providing her with a range of stimulation that more closely matched the limited level of arousal she could tolerate. However, as I restricted my own expressiveness, at times I became fidgety and squirmy. She seemed oblivious to my moments of discomfort.

Gradually, her tolerance for affective arousal increased and I could become more expansive. She was able to talk about affectively more difficult material. Her voice remained soft but with more contouring. She spoke about social relationships and acting auditions, which raised the spectre of competition. But she felt that she had no right to live. She withdrew from these situations lest she draw attention to herself. Initially, these explorations had little effect on her life. Our dialogue, however, did increase the affective range that she could tolerate in the sessions.

During the first two years of the treatment, Karen moved from descriptions of her environment, that is, the inanimate world, to descriptions of interpersonal relationships and to explorations of her subjective states. At the same time, I also shifted from summaries of the previous sessions to elaborations of her feelings and reactions. Sometimes anticipating her formulaic opening, “What shall we talk about?” I began sessions by asking her how she was feeling. Sometimes, before she responded verbally, her right upper lip would twitch and constrict briefly or her leg would jiggle rapidly. I came to understand these signals as an indication that she was tense and had been feeling moody, depressed, or without energy since our last meeting. We focused on her specific reactions and tried to find a context for them. I detailed nuances of feelings and moods, such as annoyance, rebuff, eagerness, enthusiasm, and disappointment. I told her that it seemed to me that she experienced many emotions as though they were annoying intrusions. After some time, I was able to add descriptions of Karen as “considering,” “hopping,” “planning,” or “expecting.” That is, I distinguished among categories of affect and time and acknowledged her authorship of her experience. I kept pace with Karen's gradually more personalized communications. Nevertheless, the extent of her visible discomfort waxed and waned. However, she did appear more comfortable about accessing,
revealing, and understanding her subjective life in both its reactive and in its proactive aspects.

Although I was not unaware of restricting and monitoring my responses to Karen, I was not following a premeditated plan of nonverbal treatment. Qualities of nonverbal communication, such as vocal rhythm, pitch, contour, and the level of arousal, are usually out of awareness, but we are able to bring them into focused attention. It was mostly in retrospect that I became aware of the salient role played by these nonverbal, mutually regulated interactions and their effect on Karen’s and my self-regulation. I assumed that, through these interactions, Karen felt some sense of validation leading to the tentative engagement of a selfobject tie.

To enable Karen to maintain the fragile developing selfobject tie, I did not make explicit the possibility that Karen was refining aspects of her experience with Brian in the therapeutic relationship. To do so could have increased her self-consciousness and her propensity toward overstimulating anxiety. She would have needed to protect herself against a repetition of another attachment and loss-abandonment sequence.

Instead, I recognized Karen’s affective reactions as well as her dread of retraumatization in her current relationships. We translated her associations, symptoms, nightmares, enactments, and hallucinations into more direct statements about herself and her experience. We discussed the vagueness that characterized much of her life as indicating what she was afraid to perceive, feel, believe, wish, imagine, or remember. My comments were directed toward recognizing her attempts at self-definition. In this way, her prior, almost exclusive reliance on drastic self-regulation through withdrawal, depersonalization, and derealization began to shift. Her sense of agency increased. For example, as her dread of retraumatization in new situations diminished, she showed a wider variation of facial expressions. Occasionally, she smiled. Furthermore, she registered for some classes, attended, and participated.

In the course of the first two years of treatment, Karen recalled her parents’ fights and was increasingly able to describe other painful events. Until we explored them, these memories had been retained as unconnected experiences. They correlated with Karen’s sense of fragmentation. In making connections among these memories, her feelings, and their current relevance, I continually depicted Karen as living and having lived a life with temporal, affective, and cognitive dimensions. I described the events to her, with some slightly increased affective elaborations. Increasingly, she could tolerate my amplification of her affect.

These memories spanned the fifth to eighth years of her life. In the earliest event we pieced together, Karen was required to mail a letter for her mother at the post office. Karen recalled feeling abject terror at having to walk past some derelicts to mail the letter.

Karen recalled that she could not leave her mother’s side. Nor could she explain to her mother why she was so afraid. Her mother encouraged her to mail the letter by telling her how big and grown up she was. We came to understand that walking alone past the derelicts meant to Karen that she would be showing her mother that she was “growing up.” She would then be telling her mother that she was able to fend for herself. I said that her fear of revealing her “growth” grew out of her belief, based on the fights she had overheard, that her mother wanted to “dump” her and, in fact, could not wait to do so. Showing independence would result in imminent loss of support. Karen responded with silent tears. This was unusual since she rarely responded to such reconstructions directly. It was at times like this that new recollections emerged.

Another memory concerned a visit to a department store where Karen had one of her first asthmatic attacks. She tried to tell her mother that she could barely breathe. She could not keep up with her as they rushed from one department to another. Her mother told her that the shopping was important and Karen should not complain so much. Karen recalled the department store visit as we were exploring how she neglected her health, teeth, skin, and allergies. I commented that through her body and frequent upper respiratory illnesses, her complaints were given voice. There she retained an eloquent record of her feelings. The twitch of her upper lip and her foot jiggles also constituted such a silent record of her moods and feelings.
Karen had come to consider her physical state as unimportant. She could now imagine that she must have felt hurt by her mother's dismissive and neglectful behavior. She had been anxious about her breathing difficulty but, most of all, fearful of evoking her mother's disapproval by complaining. Her solution in the department store had been to redouble her efforts to stay close to her mother, attempt to dampen her own arousal, and hope that the ordeal would soon be over.

A third memory involved Karen's sleep difficulty, which continued even after the parental fights ceased. To cure her sleep difficulty she had been confined to her room. While exploring this symptom, Karen reported that she currently had been feeling a sudden urge to travel to Iceland. She then recalled that she had attempted to deal with her sleep problem by putting herself to sleep in an empty bathtub. There she could fall asleep because “it was quiet.” But, most important, the “whiteness” and the hardness of the tub felt so good. It afforded her a sense of security and protection. When her parents discovered her, however, she was sent to her room immediately after supper so that she could try to get to sleep early.

Obediently, Karen remained in her room. She watched the outside world from her window. She felt excluded and frustrated and began to draw on the walls of her room. These creative, exploratory, assertive efforts were quickly punished. She was given a bottle of cleaning fluid and told to undo the damage. Later, however, she was presented with a paint set, but she felt too resentful toward her parents to use it. The paint box was never opened. Some years later, in a similar vein, she was given a chemistry set because she had shown some interest and ability in her science classes. Aside from presenting her with the paints and chemicals, though, no one in her family took any interest in her. No one inquired about the two sets. Neither was ever used. Karen acknowledged that she would have liked to use the paint and the chemistry sets but could not bring herself to do so.

Karen clung to her room until she was dragged by her parents to college. Her room was her refuge, and she felt protected in it, even though alone. Her banishment and “voluntary confinement” to her room paralleled my sense of her inaccessibility in the therapeutic relationship. I made this connection with the expectation that Karen's inaccessibility could be explained and thereby diminished more directly. She thereupon dreamt of a “barren countryside.” In association, she recalled hallucinatory experiences. When she was confined to her room and would look out of her window, she sometimes saw cars go by without drivers. We discussed the “barren countryside” dream, a self-state dream, as conveying her sense of barrenness. We connected it to the “aimlessness” depicted in her hallucination. I told her that she depicted herself as living in a world in which no one was at the wheel. Perhaps she longed for someone in her family to take an interest in her and assume some control. I also inquired whether she might be feeling this way currently in her treatment. Such heavy-handed transference queries never yielded much. On further reflection, however, I felt that my expectations of her exceeded a level of functioning that she could tolerate. Through her dream and her recollection of the hallucinations, she was reminding me of her still-depleted state, her barrenness. She was letting me know that I should not rush ahead of her (as her mother had in the department store) and lose sight of the severity of her difficulties. Her dread of being dumped at the first signs of “growth” still prevailed.

The three memories of being at the post office, in the department store, and confined to her room constitute a series of model scenes (Lachmann and Lichtenberg, 1992). Each one shaped segments of our interactions, though the “confine” theme dominated the others.

The model scene of standing in her room and looking out at life through her window gathered together a number of prior salient issues and shaped subsequent experience. In her room, she was protected from the injurious expectation of her family and the “noise,” and potential exploitativeness, of her peers. In her room, she did not need to fear that she might “blow others away” or become an object of envy. She also avoided the danger of feeling helpless, frustrated, and out of control. Through her continuous self-sacrifice, she maintained a firm grip on her parents' tie to her and her claim on them.
The mother-daughter relationship, encapsulated by the model scenes, depicted patterns of mutual regulation that tilted Karen toward solitary self-regulation. At first, she attempted to regulate heightened, painful affect states, such as her terror at the post office and in the department store, by trying to elicit her mother's participation. She plead with her mother at the post office and clung to her in the department store. Feeling ignored, she expected that independent steps would lead to abandonment. Therefore, heroic efforts at self-regulation were undertaken. In essence, drastic self-regulation attempts substituted for a balanced integration between self- and mutual regulation (Tronick, 1989).

By the time Karen was confined to her room, she had come to tolerate her aloneness and restrict her activity. Her efforts to engage her family had all but ceased. Her physical symptoms and her hallucinations increased her withdrawal. She felt ineffective in engaging her parents and confined herself to altering and influencing her physical and subjective states. Drawing on her walls served as a desperate signal for attention. But her refusal to touch the paint and the chemistry sets suggested that her withdrawal contained a significant degree of self-sacrifice and defiance. Karen could not risk putting herself in the position of expecting recognition from her parents and being disappointed. To avoid this danger, she kept her creative and intellectual interests to herself. She lived out her grim, unconscious belief (Weiss and Sampson, 1986) that she had "no right to a life" (Modell, 1984). Her suicidal preoccupation, her neglect of her physical well-being, her propensity to disregard physical illness, her social withdrawal and minimum functioning in life, her retreat from attention much as she desired it, all converged in her conviction that her parents' life (and hence the world) would have been better off had she not been born.

Her relationship with Brian in late adolescence was a notable exception to these convictions. Through her relationship with him, Karen had retained some hope for a reciprocal connection and sensual and sexual responsivity. A significant sector of her life had evidently been left relatively intact and revived in this relationship. However, overall her development remained constricted.

Karen developed physical symptoms in lieu of accusations and complaints, withdrew from people, and found solace in the bathtub. As a solution, the bathtub differed from the others in that she created her own protected environment. Her further confinement to her room became an enforced exclusion from her family. Yet it provided some protection against the overstimulating parental quarrels and her parents' obliviousness to her needs.

During the treatment, the self-protective aspects of Karen's bathtub experience reappeared, symbolically transformed as a visit to Iceland. In Iceland, she wrote poetry and made new friends. Karen began to acknowledge the talents that were unrecognized by her family. Her creativity had remained sequestered in her private world with considerable ambivalence. For example, she studied acting but did not perform.

Convinced that she had been a burden to her parents and the source of their difficulties, Karen considered her solitary confinement to be justified. In refusing to make use of the resources that her parents gave her, she found a self-defeating but nevertheless modest triumph. Within the confines of her imagination, creative elaborations of her experience continued in silence and in private. These could be accessed in the course of her treatment and became the imagery of her poetry.

Karen had written poems at various times in her life. During her second year of treatment she turned to writing poetry in a more determined way. A poem she brought to a session was dedicated to the memory of Brian. In it she depicted her loneliness and her alienation from her family. She ended with a plea to Brian, "Run after me but never let me go."

To "use" therapy, for which her parents paid, meant to Karen that she had to surrender her defiance and to capitulate to them. She had not used the paint box, the chemistry set, or the acting classes. Why surrender now? It became clear then, why, during the first two years of treatment, she continued to indicate that she had made no progress and that she was depressed as ever. On the basis of Karen's failure to work and earn money, her parents echoed her feeling that she had not made any progress in therapy. I asked
Karen what would happen if her parents were to stop their financial support of her. She said, "I would probably be dead now." It was as though Karen were giving her parents another chance to decide, do you want me to live or not? Since the financial support included payment for her treatment, I also understood her remark to allude to her need for therapy and its importance to her.

During the first two years of treatment, Karen usually came to the sessions encased in the room in which she was isolated by herself and her family. She either stayed in her room literally, by not coming to sessions, or figuratively through her communicative difficulties. Often sessions felt to me as though we were meeting for the first time. She never made any reference to what had gone on in a previous session, so I did. She did appear to be moved by some of my affect-laden descriptions of her experience. When she was moved, tears would roll down her cheeks. Usually, she could not say why she was crying.

In these first years of treatment, Karen missed at least one of her three weekly appointments and arrived late for the other two. Missing sessions or arriving late increased her sense of failure. When I gently inquired about this pattern, she told me that it was an achievement that she could get herself to the sessions as often as she did. During this time Karen also had two abortions, to which she reacted with increased depression. Although we had discussed her difficulties with a boyfriend who kept coming in and out of her life, she did not mention the abortions until the last minute.

Toward the end of the second year of treatment, Karen made the second suicide attempt. During the first two years I had referred Karen to a psychopharmacologist, but she did not take the medication with any regularity. Fortunately, the unused medication was not at hand. Instead she used whatever was in her medicine cabinet. Following this attempt, I met with Karen and her parents twice. The parents could not grasp the severity of Karen’s difficulties. Her mother stated, "We all get rather blue sometimes." I felt that Karen was still a high suicide risk.

After this suicide attempt, waiting to see whether or not Karen would arrive for her appointments became very anxiety arousing for me. I felt that, without some more active intervention on my part, her depersonalized state and the suicidal potential would continue. I needed more reliable and intensive contact with her. I needed to feel less worried and to feel that I had a chance of reaching her.

Thus, at the beginning of her third year of treatment, I decided to telephone Karen about two hours before every appointment. I reminded her of the time of our meeting and told her that I looked forward to seeing her. Within about three or four months, Karen no longer missed sessions.

Karen had engaged me sufficiently that I began to feel desperate. When I had decided to call her, I was not conscious of her plea in the poem, "Run after me but never let me go." However, I was evidently responding to it. In retrospect, my enactment exactly matched the presymbolic quality of many of Karen's communications. We may ask if her longstanding, continuously reinforced conviction that she was fundamentally unwanted would have budged in the face of verbal interventions and explanations alone. Could attuned understanding have better facilitated the therapeutic process? Were my calls an extension of empathic immersion in her subjectivity? Or was I requiring Karen to connect with me on my terms and at her expense?

Though valid, these questions imply that my self-regulation and my role in the interactive regulation could have been reduced or eliminated. Although a dramatic departure from customary analytic work, the telephone calls emerged out of a context in which my capacity to tolerate anxiety had reached a limit. Furthermore, my enactment concretely made the interpretation to Karen: You are wanted. In retrospect, it is clear that this enactment was a critical part of the regulatory process and therapeutic action in this case.

Despite Karen's detachment, her responsiveness to some of my comments did evoke an intense engagement on my part. Her dramatic response to my calls by coming regularly to sessions indicated how profoundly she could be influenced by me. Moreover, her response exactly matched what I needed to feel, so that the treatment, and she, had a chance. In the earlier stages of the therapy, her sense of efficacy had been promoted as I restricted and dampened
my natural responsivity. Now my sense of efficacy was promoted as she expanded her responsivity and reorganized her relationship to me and the treatment. Thus a complex and intricately matched mutual regulation took place.

By the end of the third year, the gradually firming selfobject tie made suicide less likely and diminished her depression. She had to admit that she had not felt so well in many years. She even volunteered that she did not think she could ever make another suicide attempt.

During the first year of my calls, if she were still asleep, her answering machine would pick up and I would leave a message. As Karen became less depressed and felt more energetic, she often left her house before my call. She would then come to the sessions without a reminder and would receive my message only upon arriving home in the evening. On several occasions I asked how she felt about my telephone calls. She told me that it was "OK" for me to call. I understood her "OK" as her only way of saying that she wanted the calls. She could not acknowledge that she needed them. In her "OK" she gave me permission to call, as if also reassuring me that I was not intruding. In this response it is apparent that Karen was still quite detached and protected herself in the privacy of her room.

By the beginning of the fourth year of treatment, Karen appeared more alive and accessible. The gradual establishment of a relatively reliable selfobject tie shifted Karen’s self-regulatory capacities toward greater tolerance for affect and arousal. Although she remained rather constricted, she gained increasing access to her own experience and to her own history. Past and current impressions gained expression in her writing.

In this fourth year Karen wanted to talk to her mother about the recent death of an acquaintance. It was an event that bore certain similarities to the death of Brian. Her mother suggested that they meet to talk about this death at a bar that had music. Karen then telephoned me. She had felt guilty about her actions at the last meeting with this acquaintance, and she was now also disappointed and furious with her mother for fending her off. Thus, in spite of her continuing state of detachment, she was able to use our tie to restore herself in this crisis.

In her fifth year of treatment, Karen’s interest and talent as a writer enabled her to enroll in a graduate program, attend classes, and submit assignments. After her visit to Iceland, she succeeded in having some poetry published. Though she still sought relationships with unstable, irresponsible, charismatic men, she was no longer so compliant and dependent. She practiced “safe sex.”

Karen’s conviction that she would cause fewer problems for her family by shutting herself away remained a dominant theme. In fact, it received continual confirmation when she visited her parents. They did not seem to be aware of her widening range of affect and ability. They told her not to come into the living room when they were entertaining friends because her depressing and uncommunicative manner put a pall on the company.

After five years of therapy, Karen emerged as an adventuresome, foolhardy, overly trusting, resourceful, funny, and still somewhat self-sabotaging person. In her own succinct way, she summarized her gain in her treatment: “I used to not be able to talk to people. Now I can talk to people.”

Karen terminated treatment after eight years when she obtained a job as a reporter outside of New York. She would call me once or twice a year to let me know how she was doing. Five years after termination, she continues to be productive and self-supporting.

Discussion

Karen’s lifelong experiences of rebuff led to a premature reliance on drastic and restricting self-regulatory measures, such as avoidance, depersonalization, derealization, and dampening of her own affect. Designed to avoid retraumatization, these measures only partially protected her. She maintained a precarious balance between self-expression and self-annihilation.

In Karen’s development, sounds had become shattering noises obstructing emotional contact. Vision had become a remote sense. She felt as though she were looking at herself and her experiences from a distance. Breathing, sleeping, and spatial orientation were impaired. Sensual-affective experiences were overarousing and emerged as physical symptoms and disruptive imagery, such as
hallucinations and nightmares. Unable to regulate affect states on her own, she avoided emotionally arousing, and thus potentially disruptive, experiences.

The relationship with Brian revived Karen's expectations of being affectively validated and part of a dyad. It rekindled her expectation that she could trust her feelings, that she could be included in someone's internal life, and that she could form a bond. We assume that the tie to Brian reengaged an earlier, precarious selfobject tie to her parents. With the death of Brian, Karen was traumatized (Lachmann and Beebe, 1997). Not only did she lose the only person to whom she felt connected, but her parents also failed to validate her profound devastation. Thus selfobject ties were irreparably disrupted.

The treatment of Karen illustrates the role of interactive and self-regulation in the therapeutic establishment of the selfobject tie. Karen's feelings were labeled, differentiated, and affirmed. Her fears of retraumatization were investigated and, over the course of the treatment, disconfirmed. As she had with Brian, she feared that attachment would lead to loss. Furthermore, her restricted self-regulatory range had interfered with her ability to tolerate the excitement and hope generated by the expectation of being accepted, understood, and included in a bond. These difficulties pervaded her friendships, classes, work possibilities, and her treatment.

Karen's immobile face, flat voice, sitting with her coat on, not looking, and having nothing to say required extraordinary measures. To reach her, the therapist had to restrict the range of affect and activity so that Karen's level of arousal remained tolerable to her. Speaking in a soft and even voice, and slowing the rhythm, increased Karen's tolerance for arousal. With a voice and face that were more alive, she began to talk about her life. The therapist was able to expand the level of his own arousal and address her fears. In turn, Karen was less withdrawn. Fragments of her history emerged, from which three model scenes could be constructed. This increasing coherence led to Karen's ability to report a dream and a hallucinatory association of "cars without drivers." Her inaccessibility and her world where no one was at the wheel could then be interpreted.

Although Karen was able to acknowledge that she would be dead without this therapy, her two abortions, extensive depersonalizations, a second suicide attempt, frequent latenesses, and continually missed appointments led the therapist to make the dramatic intervention of telephoning her before every appointment. That Karen was able to respond equally dramatically by coming regularly enabled the therapist to feel that he could continue to work with her. The treatment had evidently mobilized a remarkable resilience in Karen. She was able to experience her own influence on the therapist's activity, and she could experience her therapist's influencing her level of arousal. For both, self-regulation was altered through these reciprocal mutual regulations. Thus, extensive work on Karen's depersonalized state and efforts to reregulate both of us set the stage sufficiently well that the telephone calls could make a dramatic impact.

We have focused on the nonverbal dimension to illustrate the contribution of self- and interactive regulation to therapeutic action. When the treatment began, solitary self-regulation was Karen's main method of survival and it was failing. The treatment attempted to open up her self-regulation so that it could be included in a dialogue. Instead of viewing analyst and patient as two isolated entities, each sending the other discrete communications, we have illustrated a view of the treatment relationship as a system. This theory of interaction specifies how each person is affected both by his own behavior (self-regulation) and by the behavior of the partner (interactive regulation) on a continuous, moment-by-moment basis.

We have illustrated how our dyadic systems view can refine our approach to the process of psychoanalytic treatment. Rather than emphasizing dynamic content, we have placed into the foreground nonverbal interactions at the level of rhythm matching, modulation of vocal contour, pausing, postural matching, and gaze regulation. This nonverbal system of self- and interactive regulation is an essential dimension of therapeutic action.

Turning to the origins of this system in the first year of life, the next chapter reviews the infant's early capacities that define the presymbolic basis for emerging self- and object representations. In the chapter following that, we review patterns of early interactive
regulation during face-to-face play. We use this research to argue that the very interactive process itself is represented in presymbolic form by the infant. In subsequent chapters, as we consider the relevance of this research for adult treatment, our intention is not the reconstruction of the adult patient's infancy, but, rather, the formulation of organizing principles of interactions in infancy that illuminate the patient–analyst interaction.

CHAPTER

4

EARLY CAPACITIES AND
PRESYMBOLIC REPRESENTATION

Contemporary research has provided us with a view of the infant as an astonishingly competent creature. From the very first hours of life, the infant is engaged in highly complex interpersonal interactions. How the infant does this, and what kinds of interaction patterns are set up, inform us about the human capacity for relatedness. In this chapter we focus on how the infant comes to represent interactions during the presymbolic period. In particular, we review the infant's perceptual and cognitive abilities that lead to early expectations about how interactions proceed. This research is used to describe the presymbolic basis for emerging self- and object representations. It addresses the most fundamental ways in which the mind is initially organized. This knowledge, in turn, is of use to us when we address adults in treatment.

Self- and object representations are addressed here in terms of their presymbolic origins. We use Piaget's (1937) timetable in placing the emergence of symbolic thought at the end of the first year, undergoing major reorganization at 16 to 18 months, and consolidating in the third year. Symbol formation is briefly defined by the capacity to imitate an object that is not physically present and to refer to an object in a way that is not defined by its physical features, that is, through a conventional (linguistic) symbol (Piaget,