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*Optimal Responsiveness in a Systems
Approach to Representational and
Selfobject Transferences**

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EDITOR'S COMMENT

The authors describe the process whereby an intervention that was intended to provide an optimal response to an evident representational transference triggered a disruption in the relatively hidden, but simultaneously operating and psychologically predominant, selfobject transference. The authors indicate that their terms *representational transference* and *representational configurations* (which are synonymous) have the same meaning as "repetitive dimension of the transference," but that they additionally imply the coexisting repetitive and transformative potential that is characteristic of these configurations. They use their case example to illustrate the challenge to the analyst's optimal responsiveness in such instances. They also demonstrate how their dyadic systems approach to the

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repair of disruptions promotes the acquisition in the patient of expectations of reciprocal responsiveness, or mutual regulation, in the process of addressing future disjunctions.

There is significant similarity between Wolf's description (Chapter 11) of the therapeutic usefulness of a blameless acceptance of participation in the disruption and Lachmann and Beebe's view of the therapeutic value of expressive recognition that the tie has been interactively ruptured and that the patient has experienced the analyst's response as nonoptimal. I would only add here, which both Wolf's and Beebe and Lachmann's clinical examples demonstrate, that, as I described in Chapter 7, the responses of the therapist following the rupture must be specific to the disjunctive issues that both patient and therapist are now facing. The principle of optimal responsiveness applies equally in situations of disruption and situations in which the patient experiences the analyst's responses to be "just right."

The authors also use their case example to illustrate the difference between a linear and transformational model of development and the implications this has for the optimal responsiveness of the therapist. In contrast to a linear model, which assumes that what the patient offers derives essentially from particular experience in the patient's past and is not significantly affected by later or current context, a transformational model recognizes the continuing influence on experiences of self and other of all stages of development as well as interactions with the therapist. This particular example demonstrates the benefit of recognizing how a later organization of self and other may better capture a certain transference predicament, defenses, and resources than an earlier one.



We heartily concur with Bacal's view, elaborated in Chapter 7, that optimal responsiveness should in fact be termed "reciprocal optimal responsiveness." We view the entire psychoanalytic enterprise as defined by reciprocal interaction, on a moment-by-moment basis. Reciprocal interaction is conceptualized within a systems model that integrates mutual regulation with self regulation (Beebe 1986, Beebe and Lachmann 1988, 1994). The terms *reciprocal responsiveness*, *reciprocal interaction*, and *mutual regulation*

are used interchangeably. We thus broaden the field of this discussion from optimal responsiveness to the larger question of the system of interaction within the transference.

We conceptualize transference as co-constructed by both partners. In this chapter, we define two dimensions of the transference: the selfobject dimension and representational configurations. Within the selfobject dimension we propose that nonoptimal interactions are as significant as optimal interactions. What may seem appropriate from the dynamic standpoint of the representational configurations may turn out to be nonoptimal from the selfobject viewpoint. Thus, the definition of what is optimal and nonoptimal must be jointly defined by both dimensions of the transference. Finally, a critical additional feature of our systems model is the recognition that these two dimensions of the transference are organized at multiple levels across developmental transformations. The case we present illustrates the advantage of recognizing how a later organization may better capture a particular transference dilemma, defenses, and resources than an earlier one.

Although they are not identical with each other, three pairs of concepts cover a similar terrain: one- and two-person psychologies, self and mutual regulation, and selfobject and representational transferences. We have previously argued (Lachmann and Beebe 1992) that the integration of self and mutual regulation is one way of articulating the integration of one- and two-person psychology perspectives. Our terms, *self* and *mutual regulation*, and *selfobject* and *representational configurations*, cut across the distinction between one- and two-person psychologies, potentially provide finer clinical distinctions, and do not carry an either-or connotation.

In our "dyadic systems view of communication" (Beebe et al. 1993), the organization of behavior and experience are viewed primarily as a property of the patient-analyst system rather than as a property of the individual. However, the individuals each bring their own range of self-regulatory capacities. A psychoanalytic theory of interaction must specify how each person is affected by his own behavior—self regulation—as well as by that of the partner—interactive regulation. The nature of each partner's self regulation affects the interactive regulation and vice versa.

A dyadic systems view incorporates a transformational perspective. Development is in a constant state of active reorganization, and transactions, between the child and the environment, undergo regular restructurings (Sameroff 1983, Sameroff and Chandler 1976). At each stage of

development experience is reorganized. In psychoanalytic treatment the contributions of each stage are recognized, not just the earliest. A transformational view can be seen, for example, in the concepts of epigenetic stages (Erikson 1950), narrative point of origin of pathology (Stern 1985), and model scenes (Lachmann and Lichtenberg 1992, Lichtenberg et al. 1992). According to this view, earlier is not deeper, and later layering is essential to full recognition of the transference.

In our proposal that transference is composed of a selfobject dimension and a representational configuration (Lachmann and Beebe 1992, 1995, 1996), we took the position that the selfobject concept is not flexible enough to encompass all therapeutic aspects of the transference. Instead it exists in a figure-ground relationship with representational configurations, defined as affect-laden descriptions of self and other (see also Lichtenberg 1983, Stolorow and Lachmann 1984/1985). Representational configurations are derived both from a person's expectations from earlier times as well as from aspects of the current patient-analyst interaction. The selfobject dimension addresses the experience of and the maintenance of the tie between self and other, as well as the requirements for cohesion, articulation, and vitality of the self. The representational configurations depict the qualities of self and other and the themes of their interrelationship. We hold that representational configurations provide the context for selfobject experiences and, in turn, selfobject experiences provide access to representational configurations. Self and mutual regulation are instrumental in organizing and transforming selfobject experiences and representational configurations.

We now turn to the one-person and two-person psychology distinction. The one-person view recognizes the patient's elaborations of his or her own experience. It emphasizes the uniquely organized expectations and fantasies to which the person adheres and that affect interactions with the analyst. This view fails, however, to give sufficient recognition to the mutual influences of analyst and patient on each other. Furthermore, the unique context of the analytic experience as it shapes, influences, and transforms the patient's experience must be considered. Whereas the one-person view underscores the centrality of self experience, the two-person view emphasizes the centrality of the interaction with the partner. The two-person view recognizes the continual, reciprocal impact of analyst on patient and patient on analyst. It underscores the analyst's monitoring of the effect of his or her theory, personality, and biases on the patient's

transferences, and vice versa. Thus, we hold that both of these positions are essential for a comprehensive understanding of the complexity of the patient-analyst relationship.

Both analyst and patient contribute to the transferences, but their contributions are neither equal nor similar. Each brings to the analytic encounter his or her own organization, that is, self regulation. In addition, the treatment relationship is organized by mutual regulation. This perspective is derived from studies of early development and recognizes the lifelong organizing effects of self and mutual regulation, disruptions and repair of these regulations, and heightened affective moments (Beebe and Lachmann 1994).

In this chapter, we consider the effects of a nonoptimal interaction and its subsequent analysis and repair. Nonoptimal interactions have a therapeutic value of their own. Although such events are not specifically planned by an analyst, they do occur with some frequency. Disruption and nonoptimal interactions are ubiquitous and an essential constituent of all communication. They are mutually regulated both in their unfolding and in their repair. Establishing expectations that disruptions and mismatches can be repaired is an essential mode of therapeutic action. It is precisely these nonoptimal interactions that provide entry points to the therapeutic re-evocation and illuminations of traumatic experience.

Through a clinical vignette, taken from the first year of an analysis conducted by Frank Lachmann, we illustrate the disruption of the selfobject tie through a nonoptimal interaction. We elaborate on the two dimensions of the transference: the selfobject dimension and the transference as organized by representational configurations. Finally, we illustrate the clinical relevance of a transformational model of development.

The patient is a 39-year-old divorced woman who was anxious and dependant to the point where, occasionally, she had been unable to function in her work as a travel agent. After several months of treatment these symptoms had abated somewhat. Then over the course of several sessions, she described the following events. She had met a man who thought she was a very emotional person and thought of himself as very blocked and distant. In his relationship with her he hoped he would learn how to be emotionally freer. She stated that she made it clear to him that she did not want to be his teacher. In the following session she reported a dream about her former therapist and

depicted her as her daughter. The next session contained descriptions of numerous incidents with friends in which she accepted their preferences about planning various activities and later felt angry with herself for being so compliant. In the final session of this sequence, she reported a dream in which she and her daughter's cat were being drenched and flooded in a rain shower. Her association led her to recall that she had to take care of the cat while her daughter was spending the night at a girlfriend's house. The patient felt resentful about being burdened with this chore. In addition, she described feeling resentful about her work. While feeling depressed and anxious she still had to conduct her business and take care of her clients.

This is clearly a selective account of four consecutive sessions. However, implicit in this clinical material were descriptions by the patient of herself as burdened, resentful, angry for being overly accommodating, a caregiver or mother to "mother" figures, an authority for her boyfriend, and feeling deprived of protection and nurturance. Others were described as embodying the qualities of demandingness for her care, and the expectation that she serve as the adult, parent, mother, teacher, accompanier, and provider.

These affect-laden descriptions of self and other constitute a series of representational configurations. Experiences of self and other are organized in line with expectations derived from an earlier time and facets of the current analyst-patient interaction as well. Such configurations may be rigidly repeated and imposed on ongoing experience. Optimally, they can be expected to transform and be transformed by the ongoing therapeutic experience.

WHAT DO WE MEAN BY "TRANSFORMATION"?

Beginning in early development transformations are a consequence of the continuous interaction between the person and the environment. According to the transformational model, intrapsychic changes produce changes in the environment and vice versa, so that neither the person nor the environment remains static from one point of time to another (Piaget 1954, Sameroff and Chandler 1976). In this process, both earlier and later stages remain influential.

The envelope of optimal interaction will contain contributions from both the patient's and analyst's background as well as the here-and-now co-constructed moment. By maintaining this perspective of developmental transformation, the analyst can avoid being drawn into a simplistic linear perspective.

In a linear perspective the age from which a particular experience, memory, fantasy, or relational configuration derives is linked to a specific level of development. A linear model assumes that material offered by the patient comes directly from the patient's past and is unaffected by the therapeutic context. It is as though analytic responses, optimal or otherwise, are akin to diagnostic formulations, based exclusively on what the patient presents and the analyst has accurately perceived.

In contrast, the transformational model recognizes both the continuing influences of all aspects of the patient's development as well as the affect of the analyst-patient interaction. Stern's (1985) concept of "narrative points of origin" of pathology reflects his finding that the capacity for symbolization that develops at about 18 months opens the door to wide-ranging reorganizations of the child's developing capacities. The narrative sense of self both reorganizes the earlier senses of self and leaves room for their unique impact on subsequent experience. In adult treatment we encounter this reorganization in narrative form in the analytic situation. It is toward this narrative reorganization that we aim our therapeutic responses.

Representations of the experiences in the caregiver-infant dyad undergo transformations throughout development. Similarly, representation of experiences in the analyst-patient dyad are assumed to undergo transformations. These may evolve into expectations of mutuality, interactive responsiveness, or, as in the present case, traumatic disruptions in the selfobject tie, and a resurgence of manifestations of self dissolution.

DIMENSIONS OF THE TRANSFERENCE

In the treatment dyad, representations of experience can be delineated along two dimensions: selfobject and representational configurations. Whereas in early development these two dimensions are indistinguishable, the distinction between them is crucial in the treatment of the adult because they address different functions and different qualities of experience. The

selfobject dimension includes the experience of and maintenance of the tie, and the requirements for cohesion, articulation, and vitality of the self. The selfobject tie can be seen as varying along the dimension of "the search for a new beginning" and "the dread to repeat" (Ornstein 1974).

Representational configurations refer to the qualities of self and other and the themes of their interrelationships. The representational configurations are both repetitions of past experiences and to some extent contain the seeds for their potential transformations. As we indicated earlier, we believe that representational configurations provide the context for self-object experiences, and, in turn, selfobject experiences provide access to representational configurations. Although representational configurations are shaped by the transactions of important relationships, they are also shaped by the person's effort to construe experience in such a way that vital selfobject functions may be derived.

Our use of the term *representational configurations* does not exclude the possibility that selfobject experiences are represented. We use this term to refer to those transferences that have been traditionally described within psychoanalysis as "object related" (see Bacal and Newman 1990). Stolorow and Lachmann (1984/1985) reformulated transference as the organization of experience and proposed that selfobject and other transferences occupy a figure/ground relation to each other (see also Lichtenberg 1983). These other transferences have also been referred to as the conflictual-repetitive dimension of the transference (Stolorow et al. 1987). We prefer the term *representational configurations* to *repetitive dimension of the transference* to emphasize the concurrent repetitive and transformative potential that characterizes these configurations. When rigid representational configurations shape the patient's treatment experience, they become foreground, requiring analytic attention.

In the treatment of adult patients, representational configurations may synopsise the subjective elaboration of important interactions from any phase of the person's life. Under optimal circumstances they continue to be reworked, as past experience is transformed at various times in life and in analysis. As past themes are reworked and relived, newly acquired resources and defensively instituted restrictions can be integrated. When these representational configurations are, for example, based on a dread of repeating character defenses (Ornstein 1974), they remain rigid and stereotypic.

THE ANALYST'S NONOPTIMAL RESPONSE

Following the four sessions described above, based on the patient's description of herself and her interactions with others, I reached for a response that might provide optimal support and understanding as well as open the patient's repeatedly dissatisfying experience to investigation. I commented that although she, the patient, might want to be taken care of, she frequently found herself in the position of the caring, self-sacrificing mother. This interpretation described a representational configuration based on the patient's narratives, associations, and dreams. No developmental origins were suggested, and no statement about the transference was directly made. I felt that this comment was in tune with the patient's expressed complaints and recognized her longing for an attachment in which she could feel cared for.

The patient immediately supplied confirmatory material with respect to her family, her parents, her brother, her ex-husband, and her daughter. Apparently she felt understood and used the interpretation to further organize past events in line with the interpretation, and in a manner that seemed to promise her a greater sense of efficacy.

However, shortly after the session the patient became increasingly depressed and confused, to the point where she felt she was unable to function in her work. She telephoned me in the evening after the session in which the interpretation was offered and asked what she could do, because she felt profoundly disorganized. In the brief phone conversation I connected her disorganized state to the session, which she had not done on her own. I told her that we would attempt to understand if something occurred in the session that disturbed her so. I realized that an intervention that I had thought captured her state and distress in a tactful and emotionally responsive manner may not have been experienced by her as optimally responsive. At that point, reestablishing the safety of the analytic setting was of paramount importance. Acknowledging the possibility that the prior session may have had a disruptive effect constituted an attempt at repair.

The patient reciprocated with optimal responsiveness of her own. She was pleased by the phone call and particularly by the acknowledgment that the disruption had been interactively organized. She had not been blamed.

Thus, connecting the patient's disruption to her experience of the prior session acknowledged the interactive organization of her disorganization and contributed to restoring a sense of safety in the analytic setting.

This ambience of safety (Lichtenberg et al. 1996) is derived both from the analyst's responsivity toward the patient and the patient's experience of the analyst's responsivity. Parallel experiences of the patient's responsivity toward the analyst and the analyst's experience of the patient's responsivity are, of course, also implicated. These aspects of the patient-analyst interaction are discussed by Bacal and Thomson in Chapter 12. With an opportunity for an analytic dialogue reestablished, a joint understanding of the patient's self-fragmentation could be addressed.

A DEVELOPMENTAL PERSPECTIVE: SYSTEMS MODEL

Stern's (1985) senses of self (emergent, core, subjective, verbal) are cumulative and are progressively reorganized. Thus, in the adult patient any sense of self may be more or less implicated, strengthened, or threatened at any point in development. In the case under discussion, the patient's core sense of self was shattered by the intervention. However, as it emerged in later explorations, it was predominantly the narrative sense of self around which her selfobject tie to the analyst had been built. That is, the predominant transference was organized by a selfobject tie derived from the idealization of the father rather than by a masochistic, self-sacrificing relationship organized in relation to the mother.

Viewed from the vantage point of linear development, the relationship to the mother refers to an earlier time in the patient's life than her idealized tie to her father. Following a model of linear developmental sequence would have led to the same nonoptimal response as was offered by the analyst in this instance. The analyst would have wrongly concluded that aspects of her relationship with her mother had not been sufficiently worked through and required immediate attention.

From the vantage point of a systems model, however, the analyst searches for the issues in the current interaction and the sense of self that are implicated. Using this approach, after the selfobject rupture, the analyst was led to an acknowledgment of the array of resources the patient acquired through her problematic but idealized tie to her father. Proceeding with treatment without sufficiently acknowledging the patient's developmental achievements would, in effect, have undermined her past developmental strides. The developmental model enables the analyst to recognize the

relevant transformations that have contributed to the patient's increasing resourcefulness and to note where developmental advances have been precluded.

A linear model suggests that the analyst tailor responses to meet needs along a developmental ladder. Crucial contributions derived from other (often later) developmental steps could be ignored if earlier origins are always assumed to be more relevant. The patient's "complaints" about having to be the caregiver touched on the extent to which her sense of self was organized by a precarious narrative in which she depicted herself and others in complex, representational configurations. This depiction invited a responsive verbal intervention. Yet, other senses of the patient's self were also affected. My tone and affect (concern and anxiety) touched the patient as well. These nonverbal aspects of my nonoptimal intervention were part of my overall communication. As it emerged subsequently, my anxiety, as packaged in my intervention, contributed significantly to the patient's anxieties and her profound disruption.

THE PATIENT'S FRAGMENTED RESPONSE

How shall we understand the patient's debilitating anxiety? Is her reaction to be seen as a masochistic enactment in the transference, or is she predominantly reacting to an empathic rupture in the selfobject tie? Should the analyst consider the disorganization as emanating from a threat to her need to maintain a self-sacrificing position through which she maintained her self integrity?

Rather than viewing the patient's response as organized entirely by her own pathology, the interactive contributions from the analyst-patient dyad as well as from the patient's propensity for repetitive, stereotypic responses were recognized. That is, we illustrate here our use of a one- and a two-person psychology perspective.

When I suggested to the patient that there might be a link between her overwhelming anxiety and the preceding session, it had a multitude of meanings for her. It meant to her that the cause of her disorganized state was not being located solely within her. Not only was the interactive organization of her experience implicitly acknowledged, but she was also provided with a valuable contrast for the self-accusations that were prompted by her disorganization. However, her initial reaction to my

response to what she told me on the phone was to blame herself for being too "vulnerable," and for being unable to retain a sense of me as a protective figure. She accused herself of attempting to "destroy," "undermine," and "undo" the help she received from me. These self accusations had been reinforced by her previous analyst who, she reported, took the stance of "observer" of her pathology. In discussing the impact of the telephone call, she felt particularly relieved because she feared that she would be rejected, abandoned, or blamed for her disorganization. She said that she now expected that her propensity for disorganization and disruptive anxiety states would be open to understanding. In offering an interactive basis for understanding her organization, I acknowledged the interactive basis for her disorganization and of her experience of my response as nonoptimal.

RESTORATION OF THE SELFOBJECT TIE

Although only clarified subsequently, the connection made between the patient's pervasive anxiety and the preceding session led to the restoration of a ruptured selfobject tie. The maintenance of this tie, and her feeling that I was invested in retaining it, enabled her to traverse the troubled waters of the crisis. Her dread that I would be hell-bent on severing this tie harked back to her expectation that her mother would abandon her.

From my perspective, the interpretation that although she might want to be taken care of, she so frequently found herself in the position of the caring, self-sacrificing mother, was an attempt to address her masochistic character structure. I had understood her to be longing for and feeling threatened by her desires to be taken care of. She defended herself against these desires through her excessive caregiving of others. Thus, through the analysis of the function served by her masochism (Stolorow and Lachmann 1980), I anticipated that her sense of competence would increase, her dependent longings would become tolerable, her sense of efficacy would solidify, and most important, she would feel understood by me.

The patient, however, did not share my perspective. The analysis of the rupture revealed that her sense of cohesion was derived from feeling overburdened and vitally needed though self-sacrificing. She perceived herself as a caregiver, and depicted those under her care—her cat, her daughter, and her analysts—as essentially helpless in the face of an inun-

dating, "rain-drenching," hostile world. She felt effective in helping them. My response undermined this source of efficacy.

From the perspective of the selfobject dimension of the transference, the patient's complaints in relation to her friends and daughter were not expressions of a desire to change those relationships. The complaints conveyed that she had succeeded in establishing the necessary prerequisites to sustain and consolidate her self-organization as an overburdened caregiver.

In her early years the patient lived in dread of being abandoned by her mother. Her mother's attention was devoted to community affairs and to maintaining her tie with her own parents and sisters. Her father's political activities required frequent moves, so that the family was uprooted several times during her first eight years. The patient described constraining herself, since she felt that any demand she made would unduly burden her mother. She expected to be able to ensure her mother's attention by being undemanding and expecting little from her. Her ability to provide for her mother gave her a feeling of stability. That is, becoming her mother's caregiver, she avoided the experience of her mother's absence. Furthermore, she ensured her own cohesion and survival by fulfilling vital selfobject functions for her mother (Stolorow et al. 1987). Although initially derived from her relationship with her mother, her self-organization underwent a crucial transformation during her puberty years with respect to her need to retain her father in an idealized position.

Although the original interpretation, that she might want to be taken care of but found herself in the position of the self-sacrificing mother, did not address the transference, per se, it nevertheless had a powerful effect on it. She felt as if I said to her, "You are a victim like your mother and I do not need you to sacrifice yourself." She felt implicitly rejected, which led to her anxiety and her profound experience of disruption. In exploring the nature of this rupture, the hitherto silent selfobject dimension of the transference became clearer as it moved into the foreground. Exploration of the ties led to the understanding of its organization during her puberty years in relation to her father. At that time it was coupled with an array of newly developing resources, and provided the patient with the sense of efficacy and competence that she drew upon in much of her later and adult functioning. Thus, in the treatment situation when the ruptured selfobject tie was restored, she felt she could address those aspects of the representational configurations that had been activated.

The representational configuration of masochistic caregiver had been the "figure" from the analyst's perspective. An empathic grasp of the suffering and self-abnegation entailed by this stance led to the interpretation. The analyst was unaware of the silent idealizing selfobject tie in the background through which the patient gained strength by providing the analyst with support. The interpretation ruptured this tie and it no longer remained silently in the background. Through the rupture, the selfobject tie became "figure" and required attention and repair.

In retrospect it became clear that, prior to the interpretation, the patient had established an idealized selfobject transference. This tie was an outgrowth of a bond with her father, organized during puberty and based on the conviction that *he* needed *her*. In contrast to the self-abnegation that was part of her provision of a supportive milieu for her mother, through the bond with her father she felt needed, valuable, and capable. Subsequently, in her life this tie to the father was repeatedly ruptured through disappointments. A combination of unfortunate external circumstances and "bad choices" diminished her father's stature in the family and in his community. The patient explained, "My father was politically very active in those years and I thought of him as a rather daring man. As he began to decline, I wanted my competence to be of benefit to him. It would make him feel strong and effective. He could brag about me to his cronies and the family. He could feel proud and that made me feel really good."

A salient feature of the patient's organization of the treatment was her proclivity to experience ruptures in the selfobject tie. Her later ties to her father had been characterized by continuous disappointments and ruptures for which the patient held herself responsible. This representational configuration containing the selfobject tie organized the transference. The representational configuration depicted her as the overburdened caregiver of, ultimately, her father. It was she who could restore him to his active and daring, idealized position. Inherent in this representational configuration is the selfobject tie in which she gains strength by shoring up her father. She could make him strong, an idealized source of vitality, and thereby derive her sense of coherence and competence. The vulnerability inherent in the selfobject dimension of the transference organized the disruptions.

The representational configuration of self-sacrifice, established initially to provide stability for her mother and cohesion for herself, was later activated and transformed to restore her father's idealized position. Just as

she had used self-sacrifice in relation to her mother to protect herself against her abandonment, she was now able to protect herself against being disappointed by her father. She imagined herself as part of her father's world, which sustained her, provided her with a sense of vitality, and promoted her intellectual curiosity. Her academic work flourished. Her world of skills and interests expanded. Her general masochistic pattern, first organized to retain a connection with her mother, to derive some nurturance through self-abnegation, was later refined and its function transformed. In being activated in relation to her father, she acquired a sense of pride and competence, as well as the feeling that she could be thought of as needed, interesting, and capable. Thus, through later transformations, her representational configurations expanded and became more varied.

The selfobject tie on which the representational configurations were built retained points of vulnerability. Unless the patient could experience herself as all-giving and self-sacrificing, and thereby bolster her potentially faltering father, who she felt needed her to restore him to an idealizable position, she feared that her precariously built world would collapse. The masochistic relationships that pervaded her life provided her with a sense of cohesion. Specifically, by providing support to her idealized father, or her analyst, she felt more solid and could sustain the resources that she derived through her father. After having established an idealizing, selfobject tie with her analyst, in parallel fashion, the interpretation aimed at the representational configuration ruptured this tie. It repeated her feeling of disappointment in that the "idealized" analyst also made a "wrong choice" in offering the interpretation. It indicated to her that she had failed to maintain him in an idealized state. Her depression and fragmentation, her sense of emptiness, worthlessness, and panic-like anxiety states were the results.

Are the patient's reaction to the analyst's nonoptimal response, her depression and fragmentation, her wish to be cared for, and her disorganized reaction rooted in an early pathogenic tie to the mother? Is her reaction based on "mismatches" and "malattunements" that were merely repeated and exacerbated in her later relationships including the analyst's nonoptimal responsiveness? Are the disappointments in her father merely screens for the early deprivations she experienced in relation to her mother? Or, does an explanation that emphasizes later transformations and disruptions fit this patient better?

We are arguing for a model that recognizes both the continuous construction and potential reorganization of experience at various stages, as well as the repetition of ways of organizing experience shaped by early interactive patterns. Such a model recognizes the constant shifts and transformations that provide a complex texture to ongoing experience and avoids reductionism (see also Mitchell 1988). It also acknowledges that each transformation generates the possibility that new resources may be acquired as well as providing new ways of organizing past experience (Loewald 1980).

In the patient's continual construction of her experience, the transformations at puberty provided vital resources for her ongoing development. At that time, the patient had turned to her father, in part, in reaction against her mother's chronic sense of victimization, as well as for self-restoration. Thus, there was a decisive time period when the patient resourcefully attempted to restructure her experience in the context of a more responsive mutual regulatory system. Feeling supported by her father, she felt protected and valued. When the father's stature began to falter, she then needed to shore him up to retain her sense of adequacy, efficacy, pride in accomplishments, and her expectations of some responsivity and mutuality. She imagined that he needed her support and he could be strong again. She attempted not to be a victim or demanding like her mother, but to be a caregiver and ally to her father in a mutually beneficial relationship. By restoring her father to his preeminent idealized position, she maintained herself intact and well functioning. Nevertheless, she became more rigidly restricted in that she had to organize her experience to emphasize her caregiving to the point of self-sacrifice. The initial tie of self-abnegation to her victimized mother was thus transformed at this stage through her attempt to restore her father. Silently, this precarious balance had been reestablished in the treatment and then ruptured.

DISTINCTIONS BETWEEN REPRESENTATIONAL AND SELFOBJECT TRANSFERENCES

This case illustrates a distinction that became apparent when a masochistic representational configuration, the necessity to repeat the experience of burdened caregiving, simultaneously performed archaic selfobject functions. As a burdened caregiver to her analyst, feeling that he needed her to

sustain him, she maintained a selfobject tie. She felt herself connected to an idealized protecting figure. Such dual "antithetical" functions challenge the analyst's ability to provide optimal responsivity in the analytic setting. What may be optimal from the analyst's empathic grasp of an aspect of the patient's experience (understanding the burden of self-sacrificing caregiving) may be nonoptimal for the patient from the vantage point of her self cohesion.

We suggest that representational configurations provide the necessary context in which disruptions of the selfobject tie can be understood. Thus, the analyses of selfobject transferences and representational configurations must go hand in hand, since they address different functions. In navigating between such rocks and hard places the analyst is bound to provide some nonoptimal responsivity, which, however, can still yield valuable further exploration.

A second treatment issue is also brought to the fore. If the analyst adheres to a model that explains the current manifestations of pathology in terms of the earliest prototypes, then the patient's masochistic stance as evolved in relation to her mother would again be addressed at this juncture of the treatment. The relationship to the mother would be seen as the deeper and more influential layer. But, the later feelings of worth and competence dearly acquired and constructed in relation to her father would then be bypassed. Although fragile and derived through a self organization that required self-sacrifice, they nevertheless provided her with intellectual and interpersonal resources. This idealized selfobject tie rescued the patient from the isolated, victimizing life that she felt her mother led and pointed her toward the more socially engaged, intellectually challenging world of her father. When these resources are bypassed, the patient is again confronted with a view of herself that emphasizes limitations, victimization, and masochistic self-abnegation, as was organized in relation to her mother.

Should the nonoptimal intervention not have been made? Ruptures in the selfobject tie are inevitable and lead to increased understanding. As Kohut has so crucially described, and as Wolf elaborates in Chapter 11, their repair is one source for the transformation and formation of new themes and expectations in treatment. The intervention jarred the patient because it conveyed to her that her analyst rejected her as his needed, self-sacrificing caregiver. Indeed, he appeared to her to be distinguishing himself as her rescuer to save her from her repetitively self-sacrificing behaviors. In the context of the exploration of the meaning and effect of the

rupture, the patient wondered if the analyst were unduly anxious about her ability to survive in her hostile, flooded environment.

Did the timing of the interpretation, the breach of empathy that it conveyed to her, reflect the analyst's anxiety? Was the analyst as worried about her as she had been about her father when she felt that he was being overwhelmed and could not survive in his hostile environment? This perception of the analyst's anxiety increased her anxiety and escalated her disorganization. In appearing as a "rescuer" to the patient, he became unavailable to her as a necessary participant in the organization of her crucial theme. The analyst was needed as the helpless but benign ally who had to be rescued by the patient through her sacrifices. His enlivened presence would serve as a source for her self-consolidation. These various themes only emerged and became clarified subsequent to the rupture.

From the analyst's perspective, the intervention seemed optimally responsive to the patient's distress about her burdened state. The intervention assumed that when this vulnerable state was understood, such understanding would be strengthening to her. Or, put differently, when the necessity to protect her vulnerable self was diminished, she would feel freer to experience her competence with a sense of pride. In the interpretation, the patient's shame-filled wish to be more dependent was also touched. The analyst had also assumed that speaking to the patient's dependent longings in nonjudgmental terms would further their integration and contribute to the transformation of other rigidly retained configurations of, for example, her overaccommodation (see Brandchaft 1994). The interpretation of the representational configuration, even though it ruptured the selfobject tie, eventually furthered the transformational processes of the analysis by illuminating and engaging these dominant, organizing themes of the patient's experience.

In this case we illustrate rupture and repair of the selfobject tie in a somewhat different way than was proposed by Kohut (1984). He emphasized that through disruption and repair, psychic functions that had not been acquired could be transmuted, internalized, and structuralized. We have added an emphasis on the acquisition by the patient of *expectations of mutuality*. Through the very process of analyzing disruptions of the selfobject tie, a representation of the expectation of mutuality accrues. This is our two-dimensional, interactive view of the transference. In the case discussed, the specific way in which the tie is interactively ruptured and repaired transformed expectations of disappointment. She developed ex-

pectations of being understood and responded to, and to expect interactive restoration of disruptions.

In the course of this patient's analysis, the most frequent ruptures of the selfobject tie were instances in which the patient's need to feel the analyst's investment in retaining the tie was jarred. Later in the analysis, when a disjunction along this line again occurred, the patient was able to say, "Look, you make sure that our tie is retained and I'll take care of my own autonomy." By this time the patient's self expectations, as well as her expectations of the analyst, had been transformed. He was no longer required to be her needy, weak ally whom she had to support. He was now expected to carry his own weight. A step had been taken toward being able to derive selfobject functions from an occasionally more playful adversarial relationship with the analyst (Lachmann 1986). Through the analysis of the rupture and its repair, she could integrate the resources acquired in puberty that she had been able to use only sparingly. These resources depended on her self-sacrifice and made her vulnerable to disruptive anxiety. She became more gutsy, assertive, intellectually active, and fun-loving; people liked being with her.

We have illustrated the distinction between the selfobject and the representational dimensions of the transference. Each serves different functions. Through the selfobject tie, the patient derived a fragile but necessary vitality and security. Through the representational configuration, the patient repeated and transformed the complex, painful defense and fantasy-elaborated experiences with significant figures of her past. Each may illuminate aspects of the other. If we confine ourselves to selfobject transferences, as crucial as these are, we may neglect a level of dynamics, namely, the themes that organize the patient's presentation of past experiences. If we confine ourselves to the interpretation of representational configurations, we may lose our attunement to the vulnerabilities in the patient's sense of cohesion.

In the clinical illustration, the analyst interpreted a specific representational configuration to the patient and thereby ruptured her experience of the analyst as a sustaining selfobject. Exploration of the rupture of this selfobject tie revealed its specific function, its developmental history, its transformation, and its place in the analyst-patient relationship. In addition, the ongoing transformation of the patient's experience in the treatment was promoted through the establishment of new, interactively organized expectations of reciprocal responsiveness, specifically, interactive repair of

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disruptions in the selfobject tie to the analyst. Analysis of the rupture established for the patient the expectation of being understood, of retaining a valued tie through interactive efforts with the analyst and without self-sacrifice. Addressing the rupture established the expectation that ruptures can be repaired and disappointments understood. Restoring the ruptures in the selfobject dimension transformed repetitive, representational themes of burdened, self-sacrificing caregiver of her weak, needy, but idealizable father.

Although the concept of developmental transformations has long been accepted in psychology, it has not been consistently applied to psychoanalytic treatment. Rather than emphasizing the early mother-infant dyad and uncovering and reconstructing this phase of development as the focus of therapeutic action, we illustrated a transformational model whereby equal emphasis is placed on the contributions from later phases of development. Analyst and patient may then be alerted to the resources and defenses derived from various developmental transformations as well as currently activated themes. Reorganizations occur as both child and environment, patient and analyst influence each other in a mutual regulatory system at each phase of development and analysis. This perspective is crucial for conceptualizing interventions as well as for guiding the analyst toward maintaining an ambience of safety, for restoring ruptured selfobject ties, and for engaging the patient's pathological repetitions toward further transformations.

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