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ORIGINAL PAPER

Voice and Cure: The Significance of Voice in Repairing Early Patterns of Disregulation

Kristin Miscall Brown · Dorienne Sorter

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Abstract This paper illustrates the value of the analyst's awareness of the importance of her voice with its various intonations in the telephone treatment of a patient with early infant/mother attachment patterns of disregulation. The authors describe the significance of a particular kind of pervasive verbal intrusion by the patient's mother and how through the use of voice pattern, tone, and rhythm in an extended period of telephone therapy, the patient was able to solidify a more secure attachment. Finally, the authors demonstrate how the verbal music in the analyst/patient and the mother/child dyads enhances self and interactive regulation.

Keywords Attachment · Telephone therapy · Voice

> The music of life shows its melody and harmony in our false note, according to the scale of our ideal. The tone of one personality is hard like a horn; while the tone of another is soft like the high notes of a flute (Khan 1923 in Knoblauch 2000)

K. Miscall Brown
49 W. 24 Street, Suite 1009, New York, NY 10010, USA

K. Miscall Brown
Psychoanalytic Psychotherapy Study Center, New York, NY, USA
e-mail: kristinmb@verizon.net

D. Sorter
26 W. 9th Street, 3B, New York, NY 10011, USA

D. Sorter (✉)
Institute for the Psychoanalytic Study of Subjectivity, 250 West 57th Street, Suite 501, New York, NY 10019, USA
e-mail: dsorter@psychoanalysis.net

Anna says to me during our in-person intake interview, looking right at me, "There is something I have to tell you." She holds my gaze as if to see if I flinch or betray some measure of worry about what she needs to tell me.[1] "Say whatever you are able," I respond. We sit quietly for a few moments. She takes in a shallow breath, "I don't know that it really means much, but I guess the fact that I have never told anyone means something....don't know what but..." She shifts slightly, her foot nervously bouncing. "My parents divorced when I was only three so my mom, brother and I were alone for most of my childhood. My mom's room was down the hall from me, and I remember that starting when I was 10, I used to wake up at about 5:00 in the morning... every morning..." she paused. We are quiet. "Did something wake you?" I inquire gently.

"Yeah, you could say that," she smiles anxiously. "It was my mother. She woke me up. Well *she* didn't, but the sound of her voice did. I first remember it when I was in fifth grade. I thought that something was happening to her when I would hear her screaming. It frightened me. I actually remember that I thought she was having a baby or something. One afternoon when I got home from school, I heard her screaming like she did in the morning. I followed the sound and found myself at her bedroom door. I was scared; she sounded like she was in pain. I opened her door and walked in....when I saw her, I walked right out. I thought I was going to throw up, but I just went to my room and turned on my music. From that day on, I slept with a Walkman by my bed. Every morning, my alarm would go off just before 5:00; I would put my headphones on so that I did not have to hear her. I did this every day until I left for boarding school in the 8th grade."

[1] Kristin Miscall Brown is the treating therapist. Dorienne Sorter supervised the case.

The sounds Anna heard were those of her mother masturbating. This early relentless and pervasive perturbation of Anna's aural field serves as a model scene of invasion and affect disregulation that characterized her relationship with her mother. In this paper, we will explore the impact of this particular form of impingement and how it affected her attachment to her mother and also, many years later, her attachment to her toddler-aged daughter, Chloe. Our interest is in the many ways that voice patterns, tone, and rhythm have played a particularly significant role in four years of a treatment that has taken place over the telephone as a result of her move out of New York City following the disaster of 9/11. Telephone sessions were a potentially challenging medium for a woman who had to fend off, mediate, tune out, and attempt to regulate an intrusion born of sound. When treatment sessions moved to the telephone, the patient/analyst bond was solid. Her clear desire to continue the work via telephone despite a long history replete with traumatic early experience with her care givers, emotional unrest, and mistrust of closeness indicated to me that I should follow her lead and continue the treatment via telephone. Through close attention to voice and a careful coordination of verbal matching and state sharing, patient and analyst have been able to establish more robust and reliable interactional patterns than those she had grown accustomed to throughout her childhood. An additional benefit of Anna's enhanced affect range has been that it has enabled her to do what her mother could not: acknowledge and ask for help with the overwhelming states of anxiety and agitation she experiences as a parent.

Telephone Therapy Literature

With the swell of fast-moving technological advances over the last decade, therapists are challenged to meet the changing needs for communication that our patients often present. Greater global communication has brought more frequent travel around the world, which often leads to patients traveling several times per year. With dramatically improved telecommunications born of fiber optic phone lines, inexpensive phone cards charging less than 3 cents per minute for an international call, satellite services such as Blackberry, and free internet phone services such as Skype, staying in contact with our patients is easier than it has ever been. No longer must there be a mandatory interruption of the treatment when our patients are not able to be present in the office setting. This ease of the technical aspects of communication, however, can present a dilemma for therapists. It forces us to study our own resistance to anything other than face-to-face communication. We have to understand the specific reasons we would choose not to continue treatment when circumstances require that in order for the patient to remain in treatment with us, we must consider the option of telephone therapy.

Manosevitz (2004) states, "For this generation, sessions or a significant part of an analysis on the telephone may not be as strange to [patients] as it is to their analysts. In keeping analysis current with the social milieu, we need to change" (p. 39). Addressing issues of regulating a relational distance, Bennett (2004) notes that telephone therapy "can be used as a means of negotiating closeness or distance for patients struggling with transitional space" (p. 240). Coen (2005) posits that the analyst must first focus on establishing safety with those patients who struggle with fears of intrusion or impingement. He suggests that the option of telephone therapy is a way to metabolize a slow growth of closeness with the analyst. Brisch (2000) explores the treatment of adults with early attachment insecurity and has noted some important factors when treating those with patterns of avoidant attachment styles:

> For those patients with a highly avoidant attachment representation...the telephone is an opportunity to remain in contact without breaking off therapy.... Most of these patients had traumatizing experiences with close care giving figures during their infant development. Such experiences cause them to have a highly ambivalent or even extremely avoidant attitude toward attachment figures altogether as they fear that their relationship with their new attachment in the person of the therapist can become as frightening and traumatizing as have been their caregivers (p. 386).

How the analyst and patient utilize the telephone will partly determine its success.

Moldawasky (2004) and his study group identified three factors related to the successful use of telephone treatment: "(1) both patient and analyst have a strong desire to continue the work, (2) there was an existing in-person relationship established during office sessions and (3) there had been successful progress on transference-countertransference issues during face-to-face sessions" (p. 5).

Attachment Theory and Adult Treatment

Early Attachment theory sheds light on the variety of ways that problematic attachments affect one's whole view of the world. Attachment theory began with the work and research of John Bowlby in the late 1950's. Bowlby posited that the attachment needs of every infant were, in fact, primary developmental requirements rather than secondary needs driven by physical hunger (1958). Gubman (2004) describes that the way that Bowlby emphasized the internalization of experiences born of the infant's "mental map." "From repeated interactions between the infant and

mother or caregiver, internal working models develop and become a template for all other relationships. After repeated interactions with a parent, the infant or child forms expectations of how interactions between herself and the parent will proceed" (p. 4). Theorists following Bowlby's work (Ainsworth 1967; Stern 1985; Main and Solomon 1986; Main and Hesse 1990; Lyons-Ruth 1999) greatly expanded his ideas to include specific styles of infant attachment. Then Stern (1985) continued the work of his predecessors in his seminal book, *The Interpersonal World of the Infant* which pulled focus onto the infant/mother dyad, illustrating in detail the multi-layered nature of mutual influence in said dyad. Many of Anna's interpersonal challenges throughout life stemmed from the early poorly regulated and misattuned attachment styles of her mother. Stern aptly points out:

> "The reason why misattunements are troublesome is that they fall somewhere between a communing (well-matching) attunement and a maternal comment (that is an affectively non-matching response). They fall closer to attunements; in fact, their main feature is that they come close enough to true attunements to gain entry into that class of event. But then they just miss achieving a good match, and it is the amount that they miss by that packs the wallop" (p. 211).

As a result of her mother's frequent bouts of dissociation and near psychotic dissolution, as well as repeated misattunements, it would appear that Anna would have been most like the "resistant-ambivalent" child based on the attachment style classifications of The Strange Situation developed by Ainsworth and colleagues in the early 1960's. In this style of attachment, the child alternately seeks and resists the parent; the child both reaches out for comfort and yet seems not to be comforted by the mother's presence.

The Adult Attachment Inventory or AAI developed by Main and Solomon (1986) is a useful tool in understanding work with adult patients (George et al. 1996, unpublished manuscript; Slade 1999). Doctors (2007) describes that the AAI "evaluates the *ways* in which attachment related events are remembered and organized. Insecure patterns of organizing thinking and managing emotion reflect specific child-caregiver systems for negotiating safety and security needs. Thus the patterns that characterize an individual's organization reflect earlier interactive, intersubjective systems (p. 7)." Thus given Anna's resistant-ambivalent attachment to her mother, it would come as no surprise that her main attachment style as an adult could be characterized according to the AAI as "preoccupied." Doctors (2007) states, "Main's preoccupied adults showed patterns analogous to those seen in [Ainsworth's] Resistant-Ambivalent children" (p. 7).

Relevant to this analyst/patient dyad and for the purposes of this paper, the most significant work is that of infant researchers focusing on the Beebe and Lachmann's (2002) concept of bidirectionality of influences in the dyadic system that affects bonding. They emphasize that bidirectionality does not imply mutuality between mother and child or between analyst and patient, rather it suggests "contingencies flow in both directions between partners" (p. 27). Such interactions include face-to-face exchanges, verbalizations and synchrony of responses, and mutuality of interchanges.

Beebe and Lachmann (2002, p. 72) discuss the similarities in communication that exist between infants and adults as well as adult-to-adult by observing that the timing, vocal pauses, and vocal rhythms are matched and influence one another in a bi-directional pattern. Beebe and Lachmann (1992) reference the work of Jaffee and Feldstein (1970) and Feldstein and Welkowitz (1978) in their exploration of what they call "vocal congruence" the process in which adults unconsciously match one another's vocal patterns. The authors find most meaningful the connection "between matching rhythms of dialogue and empathy and affect" (pp. 95–96).

In a telephone therapy, face-to-face exchanges are absent except through memory of facial expressions or fantasies of the expressions on each other's faces. When expression by voice is the only modality, non-verbal components of communication are necessarily captured auditorily.

Beebe and Lachmann (2002) state:

> In a bi-directional system, each person's behavior is predictable from (not "caused" by) that of the other. We are both influencing, and being influenced by, our partner's words and actions. Particularly at the non-verbal level, mother and infant, as well as analyst and patient, participate in a moment-by-moment coordination of the rhythms of behavior. This is the fundamental nature of social behavior. Each partner has continuous rhythms of behavior, for example, sound and silence, movement and hold. Even the moments of verbal or gestural "silence" are communicative. The rhythms of behavior of two partners are always coordinated in some way, usually outside of awareness (pp. 25–26).

For Anna, the silence of nighttime became a haunting precursor to her mother's loud and relentless verbal penetration. When Anna needed her mother's presence, her mother was often subsumed by distance and dissociation as a result of her own history replete with multiple layers of trauma. Unpredictability was the operating principle in Anna's relationship with her mother. What was outside awareness in her relationship with her mother was not only

the "rhythms of behavior" but also the notion of awareness itself. To know more was to feel more, as we discovered in our work together, and to feel more in her mother's presence was potentially a recipe for collapse. Anna remembers yelling at her mother about something innocuous when she was a teenager and her mother's response was to put her fingers in her ears and cry, "Stop! Stop! You're hurting me!" As Anna shut out her mother's voice, her mother shut out Anna's voice. Both Anna and her mother were overwhelmed by voice and became cocooned in their own worlds.

Patient History

Anna first came to see me about a year after she married. She was living with her husband in New York City but spending most of the day alone, as she had not found a job that she enjoyed or could commit to. She was driving down the road one day and thought to herself, "You know, things would be much easier for everyone, myself included, if I just ran my car into a tree...." This level of despair frightened her deeply and though she remembers wanting to "just move on with [her] life," she realized that in order to have any semblance of one, she needed to talk. She desperately wanted to have a family of her own but felt a deep sense of emptiness that not only concerned her but also mystified her. "I feel like I should be really happy. But I'm not and I don't know why." She called and made her first appointment.

Anna's father left her mother when Anna was three and was never again consistently involved with Anna or her sibling. Anna recalled feeling regularly like she was a burden to her mother. The slightest upset would send her mother into a rage or into a mass of tears on the floor, crying that her children didn't understand her. Anna remembered many occasions when she would find her mother chattering to herself in a manner that frightened Anna. She also remembered many occasions when she would visit with her father for a summer vacation and tell him that she did not want to go back home to her mother. "Instead of asking me why, he just looked at me blankly and said everything was fine...but he married her; he lived with her. He knew she wasn't fine." She was similarly ignored by her grandmothers, the only real parent figures she had as a child. Though they tended to her by ensuring she was well clothed, taking her out to lunch and grooming her to become a proper upper class lady, they, too, did not tune into her desperate pleas to be rescued from her mother. Some of those pleas included refusal to do any work for school, difficulties with peers, and clear signs of anxiety and trauma such as head banging. "The best thing my grandmothers did for me was to decide that I needed the discipline of a boarding school. Sounded good to me; it got me away from my mother." But because the unacknowledged burden of her mother's instability and her father's abandonment were never spoken about, Anna just turned inward and moved onward, resigned to the belief that no one genuinely wanted to hear what she truly felt or thought. Thus she hid behind her stunning beauty, simultaneously hoping and dreading that someone would ask her what was really going on underneath the veneer she so carefully protected.

In face-to-face work, I came to understand that Anna obscured affect behind an engaging smile. I felt thrown off in the beginning when she would report an event that seemed to be quite disturbing listening to her words, but her smile belied the words. I came to discover that she was not aware that her affect and words did not match. Additionally, as a result of a tacit lack of attention on the part of most adults in her life as a child, Anna had no words for her emotions. This resulted in a terrible internal terrain of loneliness and wordlessness about her own experience. She had been so accustomed to accommodating her mother that her own world of emotions was a far off universe, unknown, untraveled, and replete with fear. I had to tune in on a micro level of communication to begin to reach her, to recognize her. Once our treatment moved to the telephone, this challenge become even more crucial as we strove to secure a strong attachment through which Anna might safely begin to navigate with me the foreign terrain of her internal world.

When Anna announced that she could no longer live in the city after the events of 9/11and that her move out of town was imminent, I was initially worried. I thought about her history of isolation as a primary coping mechanism and was concerned that she might just disappear into that old, safe way of protecting herself. Moreover, I really enjoyed seeing Anna twice weekly in person. But because I also knew that we were well into a deepening treatment, I agreed to continue our work by phone. It was only as the move came closer that I realized that part of my resistance to phone treatment involved my own difficulty with the fact that I would miss seeing her. Interestingly, as I imagined how much I would miss our face-to-face sessions, I became curious about Anna's potential unconscious need for a certain kind of regulation of our closeness and connection. For Anna, this was a movement toward safety. For me, it symbolized a loss. Gaze and physical proximity were crucial elements I had come to rely on as staples of my analytic listening that were no longer present. And then there was the fascinating element of a kind of parallelism. In her childhood Anna gained control over her mother's aural intrusion by putting on earphones at 5:00 every morning. Now she could again be in control by holding the telephone for our sessions. This time, however, it

controlled tuning in rather than tuning out. I knew it was far too early to make an interpretation of this kind. So I chose to listen and to yield to her unconscious communication of a need to contain our contact in sound alone.

Because Anna and I no longer had the added information from session to session of eye contact, body language, or a simple smile of acknowledgment, I began to listen very closely to how we *spoke* to one another. The move disrupted the nonverbal components of our vis a vis relationship, thus it became important for us to reestablish only through voice what had come so naturally to us when we met in person. At first, I had no idea what I was listening for, but I began by closing my eyes as she spoke. It is said that when someone loses her hearing, her eyesight and acute awareness of vibration sharpens and when someone can no longer see, his ability to hear and sense movement is magnified. By encouraging the sensory deprivation of eyesight, I sought to increase the sensitivity of my hearing. I intentionally allowed myself to be blind. It was very hard at first. I was agitated and jittery. I wanted to ask Anna what she was doing or how she was sitting. I couldn't find a comfortable position in my own chair. But when I asked Anna how the transition to phone was going for her, she remarked that it worked really well because it allowed her to go about her day but then take a purposeful break to focus on our session no matter where she was. Sometimes she would call from the park in her car. Sometimes she would sit outside on her patio in the sun while we spoke. Anna had found ways to be in control of vocal sounds. What once was an intrusion became something that she now welcomed. She seemed to be adjusting better than I. But after a handful of sessions, I settled into my blindness and began to listen.

Pattern, Tone, and Rhythm

When we turn our attention to words shared within the analytic dyad of patient and therapist, dialogue takes on a rich, multiply layered form. Knoblauch (2000) noted the importance of micropatterning of repetitive rhythms and its variations for regulation of affect and sense of self with other as "ordered, relatively safe, and predictable or disordered, dangerous and chaotic" (p. 19).

The early morning wakings Anna endured serve as a poignant example of a sense of self with other that is "disordered, dangerous, and chaotic." The loneliness and isolation Anna experienced each morning as she ensconced herself behind her wall of music was emblematic of her self with mother that was, in fact, quite disordered, certainly chaotic and likely dangerous. Anna learned to expect erratic, crazy, inappropriate behavior from her mother. "It always felt like we were a burden to her, like she never really wanted to be a mother." When I asked Anna about her earliest memory of her mother, she recalled a photograph she found later on as an adult. "My mother is sitting on the couch with my brother, David. He's grinning at the camera as he sits beside her on her left. I am propped up on a pillow on the other side of her...she is holding a bottle, feeding me. It's the look in her eyes that still stands out for me...she is just staring off into space away from David and away from me. Her left elbow is on the back of the couch propping up her head. Her other hand is attempting to feed me, but she's looking away from me, staring off into space. She couldn't be more disinterested or disconnected." Thus Anna felt both distant from her mother and terribly overwhelmed by her, a paradox that would likely have made her attachment to her mother disorganized and patterned by instability.

Vocal rhythms (Beebe et al. 2002, 2005) become particularly important in the absence of the other forms of face-to-face interactions. Some basic definitions of sound (Merriam Webster 2007) provide the necessary foundation for attending to the dynamics of voice:

- Tone: vocal or musical sound of a specific quality ‹spoke in low *tones*› ‹masculine *tones*›; *especially*: musical sound with respect to timbre and manner of expression
- Rhythm: (1) the aspect of music comprising all the elements (as accent, meter, and tempo) that relate to forward movement; (2) movement, fluctuation, or variation marked by the regular recurrence or natural flow of related elements
- Pattern: a natural or chance configuration

Taking into consideration all three dimensions of tone, rhythm, and pattern, I realized that treating Anna via telephone would require a bit of intuitive improvisation. I would have to match her rhythms in order to determine whether or not I encouraged or discouraged progressive communication. I would need to harmonize with the tone that felt most organic and then listen for the quality of Anna's response. I would also have to work to notice if there were any particular patterns or manners of speaking on either of our parts that enlivened flat effect, deadened alive affect, or simply encouraged Anna to say more.

As our work continued over the years, Anna's relationship to her daughter, Chloe, came to the fore. Prior to having children, Anna said she absolutely wanted to parent differently than she had been parented. Once she had a child, however, she found it difficult to carry out that intention. Anna described Chloe as a hyper vigilant baby who remained so as she developed. Chloe was easily excitable, difficult to soothe, and attached to Anna in a similar resistant-ambivalent attachment pattern, much like

Anna's to her own mother. Similar to the resistant-ambivalent child, Beebe and Lachmann discuss the "insecure-resistant" child: "Insecure-resistant toddlers both seek the mother and resist the contact, failing to be comforted" (Beebe and Lachmann 2002, p. 154). Anna related that Chloe whined incessantly when she and her daughter were together. Nothing Anna tried in her efforts to meet her daughter's needs ever seemed right. Given Anna's anxious response to tone, rhythm, and vocal patterns, Chloe's vocalizations drove her to distraction and frustration. What was worse for Anna was her knowledge that Chloe appeared to be nearly angelic when with anyone else—such as her babysitter or father. Depending on the day (and I would suggest depending on her dominant affect or mood), Anna's response to Chloe's shrill, whining voice vacillated from "well, I just try to limit the choices and keep the conflict to a minimum" to "what the fuck am I doing wrong with this child?! I don't see ANY other kids act this way and what's worse, she only acts this way with me" to "I should never have had children...this kind of ability to freak out that Chloe does regularly comes directly from my bloodline. I had no business reproducing." Listening to these various responses, I had to regulate my own aversive feelings toward Anna's intense and fierce words and affects as she vented. In the heightened affective moments between Chloe and Anna, it was hard for Anna to regulate her own affectivity. This challenged her to maintain her own sense of internal equilibrium. Anna often became over-stimulated and unable to optimally respond to Chloe's over-stimulating behavior. During our phone sessions, matching Anna's vocal rhythms or tonality while maintaining a focus on my internal equilibrium, I implicitly offered her a moment of recognition, the space to be mirrored. I worked hard to imbue a feeling of safety by matching her tone and rhythm hoping to expand her response options beyond that of dissolving into a mass of unregulated, overwhelming emotions. As I listened to Anna's tales of frustration with Chloe and her unceasing needs of her, I found it helpful to focus on my own breathing. The following is an example of a familiar exchange between Anna and I on a "bad day" with Chloe:

> Anna: I can't stand it→it's never enough with her→no matter *what* I do, it's never enough and she is never satisfied and it's one crazy emotion after the next. (Extended pause[2]) I want to just scream at her to shut the fuck up.[3]
>
> Th.: I can hear how frustrated you are→it's as though you can't ever get it right→no matter *what* you do. (Matching pause) And if she would zip it already, you wouldn't feel so totally overwhelmed.
>
> (Another extended pause)
>
> Anna: Yeah!
>
> (Shorter switching pause)
>
> Th.: (*Pitched affectively softer by one or two notches*) It is so difficult to manage how overwhelmed you feel with her when she is looking to you to help her with how overwhelmed she feels.
>
> (Therapist matches patient's duration of pause)
>
> Anna: (*matching my affective pitch*) Yeah (slightly longer pause. Patient reflects on her own sense of being overwhelmed) and I just wish she could get herself together. (Pause) It's the meltdowns that kill me; they make me want to walk out of the house and leave her there.
>
> (Brief pause)
>
> Th: (*a notch lower in affect*) Yes, because it's so difficult to know how to respond when nothing you do calms her down (*pause*). So I guess part of what makes this hard is that you are then left to feel a kind of anxiety of helplessness...can't seem to make it better.
>
> (Lengthy pauses).
>
> A: (*following my notch lower*) I can't...I hate it. (Matches pause duration) I mean I know it's hard for her because I think she picks up on my anxiety.....[4]
>
> Th: .....You both pick up on one another's...it's hard for you both.....

The above exchange represents a particular flavor of turn taking in which we both participate. In response to what I heard as a shallow chest breath accompanied by staccato-like rhythm, I deepened my breath but mirrored the rhythm. My staccato responses were slower than Anna's utterances, but they resonated a similar affectivity. I simultaneously made room for 'big' affect by spontaneously connecting with my own emotions in the moment while also regulating my responses by carefully pitching my tone gradually lower than hers, hoping to encourage an underlying solidity that could hold the affect that felt so overwhelming to her. "We can hold these big emotions together" is the verbal representation of that function. In my experience of her heightened affectivity, I needed to monitor my own closely. If I was too unresponsive, she was left alone with her own frustration in a way that reflected that early isolation; if I over-shot my response and became too caught up in my own reaction, then she remained hyper-stimulated and over-aroused without means of understanding how to mediate her own feelings in the

[2] Parenthetical descriptions of the nonverbal communication in this exchange are derived from Beebe et al. 2005).

[3] The arrows indicate continuous speech. The emphasis here is on the uninterrupted rhythm.

[4] This long ellipse signals a feeling of tapering reflection that occurs in this moment of our turn taking.

presence of Chloe. The parallel to her relationship with her own mother is clear. When Anna's mother was anxious, frustrated, and angry, she was unable to regulate or modulate her emotions and would often fault Anna for causing her upset. Anna tended toward a similar pattern. As her therapist, it was imperative that I provide her with a means of holding and regulating powerful emotions in a way that her mother was never capable of offering. By doing so, I offered Anna another way of responding to Chloe's challenging affect states.

Knoblauch discusses this kind of interchange with an emphasis on what Lachmann and Beebe (1996) term "violation of expectancies."

> My approach suggests that violations of expected patterns of repeated interactions can be more precisely observed as shifts in the micromoment exchanges on rhythmic, tonal, and turn taking dimensions of the analytic exchange. These shifts represent anomalies in the patterning of nonverbal communication and constitute the feeling level that catalyses the experience of a violated expectation. They represent the microbuilding blocks out of which a pattern of interaction is shifted (Knoblauch 2000, p. 48).

Thus by not responding to Anna's distress in the way she came to expect her mother to respond, Anna and I began to shift the realm of the expected response to open to new forms of interaction.

Central to Anna's mother's own inability to respond to Anna's varying states as a child stemmed from her own traumatic history. This is keenly relevant as it reflects an important dimension of the pattern of trauma repetition and its deleterious effects from generation to generation. In his article, "Intergenerational Maternal Violent Trauma," Schecter (2003) makes an illuminating claim:

> Based on clinical observations by my research team we have noted that distress of the child under four years of age, who has not yet developed the capacity to regulate his or her own emotions, often becomes a posttraumatic reminder for caregivers who have memories of their helplessness, horror and outrage during a violent assault or memories of violent perpetrators who also had extreme difficulty modulating their negative affect and hostile aggression (p. 126).

In this treatment, two generations present with a challenging interpersonal dilemma: From her relationship with her traumatized mother. Anna learned early on to discount and disconnect from her own needs and feelings, particularly those that created reactions of anxiety, helplessness, or fear in her mother. Thus face-to-face with her pre-verbal child who is also constitutionally high energy and emotionally more precocious than she can manage on her own, Anna often feels jettisoned right back to her own feelings of helplessness and over stimulation. But she cannot retreat into isolation, as she knows she needs to respond to Chloe. By engaging outside of conscious awareness in a coordinated turn-taking exchange with me, she became more able to meet Chloe in a similar exchange. As she and I practiced this turn-taking, more and more it became something totally outside of my awareness, a kind of procedural knowing. Just as in the case of Winnicot's good-enough mother, the attunement became a part of a *nonconscious* process. At the same time, I thought it important to impart to Anna in a kind of psycho educational fashion the impact of arousal, affect regulation, and intergenerational transmission of trauma. Not surprisingly, when Anna heard me talk about these dimensions of relating with others, her relief was almost audible. She so often feels like an island, alone with these problems with her daughter, isolated with this traumatic history. In these moments of understanding, her self-critical tone dissipated and in its place I could feel the beginning compassion for herself as well as for her daughter. What I would not interpret to her directly was how she and I engaged in this procedural knowing. That is the place where I felt it essential to provide her with an attuned, regulating experience without interpretation or explanation.

Discussion

As therapists we rarely have moments of absolute assurance that what we do produces positive change for the patient. It is hard to know with certainty what really changes or shifts, but we do have clues. In my telephone work with Anna, I have had to look and listen very closely to our relationship to guide me. A few important markers of our mutual and progressive communication over the years have been steady throughout the treatment. Anna has remained one of my most committed patients. Despite her very busy life as a mother, she calls in regularly to our sessions, rarely missing and always rescheduling if she will be away for our scheduled time. Further, despite Anna's early need to hide behind niceties, Anna has revealed to me feelings that in the past she would have kept to herself for fear that they would have made her a "bad person." She disagrees with me now when she once would accept my words without question. She laughs with me and engages her wonderful wit, all symbols to me that she increasingly inhabits herself in my presence; she doesn't hide out behind a smile of words. And then I also look to the life of the patient outside the treatment room to tell me if growth is happening. She has friends with whom she shares genuine connection and she is far less isolated. Her

relationship with Chloe continues to cause anxiety and frustration but she rides the waves, regulating her own and her daughter's affect with a little more confidence each time. And yet doesn't pretend that it isn't hard for her to be Chloe's mom. Then there are those precious golden moments when the presence of growth is undeniable. Not long ago, while on a phone session with Anna, I was privy to an exchange between Anna and Chloe that reassured me again that Anna and I needed only continue the work as we have been.

Chloe had come into the room while Anna was on the phone with me and asked Anna if she could lie on her lap. The following is the exchange I heard between them:

C: Mommy, I want to put my head in your lap.
Anna: Well, mommy is on the phone...remember, Mommy talks on the phone for an hour on Tuesday afternoons?
C: Uh-hun
Anna: So if you can lay here with me and let me talk on the phone, you can stay here.
C: Ok.

Anna resumes talking to me about the topic at hand and after about 30 seconds or so Chloe interjects:

C: No, mommy, you aren't patting my head the right way....do it like this.
Anna: [laughs lightly] Oh, ok, I wasn't doing it right.....is this better?
C: Uh-huh

Anna resumes talking to me and again about 30 seconds later....

C: No, mommy, you're moving your hand too slow....pet me like THIS.
Anna: Ooops, I can't get it right....ok, like this?
C: Yeah...uh-huh...like you're petting the kitty.
Anna: Oh, ok, like I'm petty the kitty....I think I got it.

As Anna resumed talking to me, I heard Chloe singing 'rock-a-bye baby' softly in the background. I smiled as I sat back in my chair and I thought of sound again...the sound of Anna's voice in my ear, the sound of Chloe's voice singing to Anna. Resonant and melodic, these sounds filled the space between the three of us in a gentle rhythm of breath, movement, pause and silence.

References

Ainsworth, M. (1967). *Infancy in Uganda*. Baltimore: Johns Hopkins Press.

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment*. Hillsdale: Lawrence Erlbaum Associates.

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

Beebe, B., & Lachmann, F., (2002). *Infant research and adult treatment: Co-construction interactions*. Hillsdale: Analytic Press.

Beebe, B., Jaffe, J., Lachmann, F., Feldstein, S., Crown, C., & Jasnow, M. (2002). Systems models in development and psychoanalysis: The case of vocal rhythm coordination and attachment. *Infant Mental Health Journal, 21*(1–2), 99–122.

Beebe, B., Knoblauch, S., Rustin, J., & Sorter, D. (2005). *Forms of intersubjectivity in infant research and adult treatment*. New York: Other Press.

Bennett, S. (2004). Viewing telephone therapy through the lens of attachment theory and infant research. *Clinical Social Work Journal, 32*(3), 239–250.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psychoanalysis, 39*, 350–373.

Brisch, K. (2000). Use of the telephone in the treatment of attachment disorders. In E. Aronson (Ed.), *Use of the telephone in psychotherapy* (pp. 35–395). Northvale: Jason Aronson Press.

Coen, S. J. (2005). Becoming comfortable with telephone therapy. *The Round Robin, 20*(2), 3–15.

Doctors, S. (2007). On utilizing attachment theory and research in self psychological/intersubjective *clinical work*. In P. Buirski & A. Kottler (Eds.), *New developments in self psychology practice*. Jason Aronson.

Feldstein, S., & Welkowitz, J. (1978). A chronography of conversation: In defense of an objective approach. In A. W. Siegman & S. Feldstein (Eds.), *Nonverbal behavior and communication* (pp. 329–377). Hillsdale, NJ: Lawrence Erlbaum Associates.

George, C., Kaplan, N., & Main, M. (1996). *Adult attachment interview* (3rd ed.). Unpublished Manuscript, University of California, Berkeley.

Gubman, N. (2004). Disorganized attachment: A theoretical description with a clinical example of a "Difficult-to-Treat" patient. *Clinical Journal of Social Work*, 32, 159–169.

Jaffe, J., & Feldstein, S. (1970). *Rhythms of dialogue*. New York: Academic Press.

Khan, H. I. (1923). *The mysticism of sound; the power of word; cosmic language*. Geneva: International Headquarters, Sufic Movement, 1973.

Knoblauch, S. H. (2000). *The musical edge of therapeutic dialogue*. Hillsdale: Analytic Press.

Lachmann, F., & Beebe, B. (1996). Three principles of salience in the organization of the patient-analyst interaction. *Psychoanalytic Psychology, 13*, 1–22.

Lyons-Ruth, K. (1999). Two person unconscious: Intersubjective dialogue, enactive relational representation, and the emergence of new forms of relational organization. *Psychoanalytic Inquiry, 19*, 576–617.

Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to Infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism?. In M. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the pre-school years: Theory, research, and intervention* (pp. 121–160). Chicago: University of Chicago Press.

Main, M., & Solomon, J. (1986). Discovery of an insecure-disorganized/disoriented attachment pattern. In T. B. Brazelton, & M. Yogman (Eds.), *Affective development in infancy* (pp. 95–124). Westport: Ablex Publishing.

Manosevitz, M. (2004). Panel: Analysis by phone. *Psychologist-Psychoanalyst, 24*(3), 38–39.

Merriam-Webster Dictionary (2004). Merrriam Webster Incorporated.
Moldawasky, S. (2004). Panel: Analysis by phone. *Psychologist-Psychoanalyst, 24*(3), 38–39.
Schecter, D. S. (2003). Intergenerational communication of maternal violent trauma: Understanding the interplay of reflective functioning and posttraumatic psychopathology. In S. W. Coates, J. L. Rosenthal, & D. S. Schecter (Eds.), *September 11: Trauma and human bonds* (pp. 115–142). Hillsdale: Analytic Press.
Slade, A. (1999). Attachment theory and research: Implications for the theory and practice of individual psychotherapy with adults. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment: Theory, reasearch and clincial applications*. New York: Guilford Press.
Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.

Author Biographies

Kristin Miscall Brown, LCSW graduated from PPSC's training program in psychoanalysis in November 2007. She maintains a private practice in psychotherapy and psychoanalysis in New York City.

Dorienne Sorter, PhD, LCSW is co-chair, faculty, and supervisor at IPSS. Dr. Sorter is also a member of the Council of the International Association of Psychoanalytic Self Psychology. She is the co-author of Forms of Intersubjectivity in Infant Research and Adult Treatment, and faculty member and supervisor at PPSC.