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What Is a Selfobject?

Joseph D. Lichtenberg, M.D.

This paper evaluates Kohut's selfobject concept by reviewing the historical context of its origin and the gradual substitution of an emphasis on experience for the ego psychological emphasis on function. When viewed as a dimension of experience, a selfobject experience has the affective quality of vitalization. This modification and extension of Kohut's original concept derives from infant research, especially Stern's revision of affect theory and Lichtenberg's concept of five motivational systems. The paper concludes with an application of the theory of selfobject experience to pathological states, especially those involving addiction.

TERMS ORIGINALLY INTRODUCED into scientific discussions sometimes catch the imagination of a broad public, often, then, the term loses the precision given it by its originator. "Selfobject" is such a term. In popular usage, selfobject has come to mean anyone who does something good for someone else. This meaning, indeed, carries some of the import of Kohut's original usage but in the process becomes simply a value judgment about a person or situation. In this study I shall examine the term from its origin and attempt thereby to rekindle the scientific intent of its originator. At the same time I shall explore the developments in self psychology that have led us to concentrate more on the concept of a selfobject experience.

Major changes in psychoanalytic theory provide a historical thread that affects the 20 years' use of the term. Conceptions based on the ego psychology and developmental theories of the 1950s and 1960s strongly influenced its origins. Reconsiderations brought about by clinical experience within self psychology and by infant research tilt our focus toward intrapsychic affective experience closely interwoven with relational and intersubjective contexts. The study of selfobjects has played a pivotal role

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in this transition within self psychology. Because of their importance to an understanding of adaptive and maladaptive self-experiences, I shall evaluate both selfobject and selfobject experience as designators of significant developmental and clinical entities.

Kohut's Clinical Discovery

Assumption 1. Observing patients with narcissistic pathology, Kohut (1971) made a major clinical discovery. He found that the patient's self-cohesion was disrupted when the patient perceived the analyst to have committed an empathic failure. With the restoration of empathic understanding, intactness and vitality of self were restored. The patient thus experienced the analyst as a component part of the patient's self and necessary for the self to maintain integrity of vital functions. Kohut couched his findings in terms based on the prevailing theories of development and functioning of ego psychology. In this usage, selfobject is defined concretely as a person supplying a necessary but absent function.

In the preface to *The Analysis of the Self*, Kohut (1971) wrote:

Some of the most intense narcissistic experiences relate to objects; objects, that is, which are either used in the service of the self and of the maintenance of its instinctual investment, or objects which are themselves experienced as part of the self. I shall refer to the latter as *self-objects*" (p. xiv).

"Self-object" is thus a special category of objects that are, in this traditional definition, depersonalized people—thus the sentence reads "objects which," not "objects who."

We also know this to be a form of speech in which object refers to people, the opposite of subject. In the sentence "John loves Mary," John is the subject, and Mary is the object, the target for his action (loving) and his emotion (affection). But in Kohut's 1971 definition, some objects are different from the Mary in our sentence; rather than being the target for an action of the subject, they do something that influences (service) the state of the subject either by aiding the subject to maintain an instinctual investment in himself or by being experienced as part of the self. The sentence would now read either "John is enabled to maintain his

love for himself by Mary” or “John experiences himself as expanded and strengthened by inclusion of Mary in his sense of self.” In both sentences John is still a subject, and Mary is still an object that, or who, affects John’s self.

Thus we begin with an unambiguous answer to our query: a selfobject is an object that, or a person who, is used by a subject in the service of the subject’s self. What we will consider during this exploration is whether defining a selfobject as person and servicing (supplying functions) is optimal or whether selfobject should be considered as a quality of affective experience with associated symbolic representations. To try to resolve the question of selfobject as person and function or experience and representation, we will follow the path Kohut traversed to arrive at his 1971 formulation, a path that explored clinical findings with a group of patients suffering from narcissistic personality disorders.

Analysts have long been familiar with patients’ protests, depressions, and regressions at times of extended separations. The explanation for these reactions seems straightforward. Patients who are in analysis regress, activating their childlike, largely oedipal selves. As part of their regression, they experienced a dependency on their analyst-parent. The rage, despondency, and dysfunctions are thus considered childish reactions—throwbacks to preoedipal holdovers. The patient, according to this explanation, simply regarded the analyst as a parent (separate object) onto whom he projected his infantile, dependent needs. Kohut (1971) observed that one group of patients seemed particularly susceptible not only to reactions of rage, despondency, and regressive retreat when facing extended vacations but “to such apparently trivial external events as minor irregularities in the appointment schedule, weekend separations, and slight tardiness of the therapist” (p. 91).

One might say that these patients were more dependent and had more preoedipal pathology. Few of these patients, however, appeared to fit in with a clinical group of infantile, clingy, dependent people. In fact when not in the throes of such transference responses, they were most often relatively independent, high-level accomplishers. Another finding did distinguish these patients from the conventional clinical picture of the psychoneurotic—they reacted with rage, despondency, and retreat not only to slight irregularities of scheduling but also “to small signs of coolness from . . . the therapist, or to the analyst’s lack of immediate and complete empathic understanding” (p. 91). Now, these reactions are an indicator not of dependency but of marked sensitivity and vulnerability

to minute lapses in experiencing intimacy and being understood. In pursuing the question to what should this sensitivity and vulnerability be attributed, Kohut concluded that his observations pointed in two directions: the particular ways by which the analyst was being perceived by the patient and the particular circumstances in which the patient was most apt to perceive the analyst in this way.

What is the particular way in which the analyst is perceived by a patient experiencing coolness, lack of understanding, or the threat of unavailability? Kohut found that the patient's response to the analyst indicated that the analyst was perceived as "archaic, narcissistically cathected, and prestructural" (p. 21). In less technical terms, Kohut believed that he as analyst was experienced by his vulnerable patients not as a separate person as, say, a father threatening castration, but as a component part of the patient's self, necessary for the self to maintain integrity of vital functions. "Archaic" meant, thus, a parent as viewed by a very young child. Kohut's view of infancy was based on the commonly held assumption that neonates experience their world as primarily narcissistic, that is, in a general state of bliss and omnipotence with no differentiation between self and other.

"Prestructural" refers to Kohut's belief that structures—meaning functions—are only gradually acquired by a process of internalization similar to the identifications that occur during mourning postulated by Freud (1917). These transmuting internalizations (that is, something done for one is changed to something one does for one's self) are assumed to occur when, in the course of successful caretaking, that is, supplying the needs of the infant, a mother has a minute failure. The infant, using prior experience as a guide, identifies with the previously supplied function and builds up capacities. Examples are being able to self-soothe, self-amuse, and self-feed. Kohut's oft-quoted statement that the baby is strong refers to his seeing the baby as ideally "designed" to fit with caretakers into a niche. This fit facilitates the baby's developing psychic structure by transmuting internalizations of functions previously performed for him by the caretaker.

In the context of an analysis, this idea means that the narcissistically vulnerable patient's self is "prestructural," that is, presumed to lack those internalized functions by which others are able to sustain their feelings of self-esteem and self-worth. The analyst is called on to supply, and is perceived to be supplying, that function through admiration of the patient or through supplying an idealized image of whom the patient can

feel a part. When a disruption occurs in this sustaining state, the patient calls on the analyst to respond to the deficit. The minute recurrences of this experience enable the patient to develop the internal structure to restore self-cohesion on his own. Whether referring to baby or adult, Kohut assumed structures or functions were built as a result of processes of internalization. Thus unempathic caregiving led to faulty internalization and absent functions. While completely supportive of Kohut's emphasis on the "fit" between caregiver and baby or between analyst and analysand for optimal and reliable cohesive functioning of self, current conceptions of the development of psychic structure give much greater recognition to innate and rapidly learned regulatory capacities (Lichtenberg, 1983, 1989; Stern, 1985).

What are the circumstances in which the patient is most apt to perceive the analyst as a selfobject whose affirmation or shared idealization is necessary for the restoration of self-esteem? Kohut found that in response to the analyst's perceived coolness, lack of understanding, or unavailability, the narcissistically vulnerable patient would experience a state of disruption of the cohesion of his self. He recognized this state of disruption by the fragmentation of the patient's normal modes of functioning and by the depletion of the patient's normal stores of energy. In the most far-reaching of these regressions, the patient's entire mind-body-self seemed in danger of disruptive dysregulation, of being outside the realm of his control.

It is significant that the patient uses negative terms when he tries to describe the experience of the fragments of the mind-body-self or of the self-object. His lips feel "strange," for example; his body has become "foreign" to him; his thinking is now "odd," etc.—all terms which are expressive of the fact that the regressive changes are, in essence, outside the patient's psychological organization [Kohut, 1971, p. 30 fn.].

In less extensive regressions the patient will complain of not feeling himself or will report reenacting some pattern such as drinking, seeking stimulation from pornoflicks, or resorting to excessive sleep and other withdrawals.

Following the permutations of these changing states, Kohut concluded that the patient's loss of functioning occurred when he experi-

enced a failure in a responsiveness he assumed to be as omnipresently available and as necessary as the air he breathed. The metaphor of air carries further; we are aware of air only when deprived of it, and then we become gaspingly aware of the function it serves in maintaining our mind-body-self equilibrium. In treatment, Kohut believed therapists first become silently the selfobject on whom patients rely to fill gaps in their self. Therapists learn of their significance to the patients when that supportive functioning is disrupted. Now something outside the patient—the empathically responsive therapist—and something inside—a function such as initiative or integration or organization—are both recognized to be missing.

In his last statement on the subject in an answer to critics of the term, Kohut (1984) wrote:

Throughout his life a person will experience himself as a cohesive harmonious firm unit in time and space, connected with his past and pointing meaningfully into a creative-productive future, (but) only as long as, at each stage in his life, he experiences certain representatives of his human surroundings as joyfully responding to him, as available to him as sources of idealized strength and calmness, as being silently present but in essence like him, and, at any rate, able to grasp his inner life more or less accurately so that their responses are attuned to his needs and allow him to grasp their inner life when his is in need of such sustenance [p. 52].

During successful analysis, the self becomes more structurally firm. “But this increased firmness does not make the self independent of selfobjects. Instead, it increases the self’s ability to use selfobjects for its own sustenance, including an increased freedom in choosing selfobjects” (p. 77).

I believe I have said enough about the historical development of the term selfobject to support my conclusions: 1. The term gives primary emphasis to a person serving a function.

2. The term was embedded in the metapsychology of ego psychology, the dominant theory of the time, as evidenced by its references to narcissistic libido, functions, and structures and undifferentiated (archaic) stages of self and object. Although Kohut later dropped the references to archaic (it is lifelong) and to narcissistic libido, the term continues to carry some of its origins.

3. The term has given rise to conceptual confusion about its placement with respect to concreteness—is it a term for a parent seen in a particular light? This view is reflected by Kohut (1977) in *The Restoration of the Self* and in my definition in 1983:

Selfobjects refer to aspects of caregivers—mother, father, teachers, etc.—who are experienced as providing something necessary for the maintenance of a stable, positively toned sense of self. The mother of an 18-month-old, who, at about the same time as the child, recognizes his hunger, functions as a selfobject (close to self as an empathic perceiver of his needs, close to an object in her providing of the food) [p. 166].

That the term continues to engender confusion can be demonstrated by the variance in definitions of recent authors. Goldberg (1988) retains the link to person while broadening the functions from those that involve only affirmation-giving experiences to those that also include experiences that involve restraining. Goldberg states:

The term selfobject, which usually connotes another person who is experienced as performing a necessary psychic function for the self, would include the range of functions that have to do with impulse control, limit setting, and others dealing with the containment of action and behavior. However, for the most part, the illustrative clinical material in self psychology treats selfobjects as primarily gratifying or enhancing, using terms such as mirroring or consolidating and avoiding those that are suggestive of prohibition or injunction [p. 204].

In contrast, Stolorow (1986; also Stolorow, Brandchaft, and Atwood, 1987) states, “The term *selfobject* does not refer to environmental entities or caregiving agents—that is, to people. Rather it designates a class of psychological *functions* pertaining to the maintenance, restoration, and transformation of self-experience” (1986, p. 389). Stolorow’s emphasis is on a particular dimension of the subjective experiencing of an object based on the function the object serves. Wolf (1988), like Stolorow, defines selfobject in terms of subjective experience. He states:

Precisely defined, a selfobject is neither self nor object, but the *subjective* aspect of a self-sustaining function performed by a relationship of self to objects who by their presence or activity evoke and maintain the self and the experience of selfhood. As such, the selfobject relationship refers to an intrapsychic experience and does not describe the interpersonal relationship between the self and other objects [p. 184].

Like Goldberg, Wolf expands the range of functions served by the selfobject from mirroring, twinship, and idealizing to include opportunities for oppositional self-assertiveness in response to adversarial restrictions. In addition, Wolf describes the necessity of "efficacy experiences" (pp. 60–62). Self psychologists have also spoken of a negative selfobject or a negative selfobject experience to refer to occasions "when the selfobject is experienced as responding faultily with corresponding loss of the patient's self cohesion and feeling of well being" (Wolf, 1990, personal communication). The rationale would be as follows. A patient comes into analysis in a state of symptomatic distress. As the patient experiences himself affirmed and understood or in the presence of an idealized person, he feels a crucial need is being met, and the symptoms disappear. Then the analyst is perceived as failing to affirm, understand, or live up to the patient's idealized expectations. The analyst who had become in the patient's mind a selfobject, that is, a person necessary to the patient's asymptomatic functioning, now is perceived as negative, a disrupter of the patient's equilibrium. The presumption would be that the patient's mind-set of a selfobject, once established, remains intact, going from positive to negative and back to positive with restoration. In this usage positive and negative selfobject both personify the analyst's either succeeding or failing to serve the functional needs of the patient. This would be consistent with Kohut's (1984) reference to a "pathogenic selfobject" (p. 6), from whom a child needs to detach in order to thrive. The pathogenic selfobject refers to a parent whom the child counts on for functional help but whose "help," like Schreber's father's, has a devastatingly pathologic effect. While "negative selfobject" is consistent with the personification of the term, negative selfobject experience would seem to be a contradiction in terms if selfobject experience refers to a vitalizing or cohesion-producing affective state.

4. Despite problems of definition, the term derives from a profoundly important clinical discovery: a group of patients react to seemingly minor

failures in mirroring and idealization as though the very fabric of self was threatened and just as dramatically are restored to functioning when they feel sustained by an empathic ambience.

The Selfobject from the Perspective of Development

Assumption 2. A contemporary theory of infantile development redefines the term selfobject as referring primarily to a vitalizing affective experience, the selfobject experience. The part-self, part-object aspect of the definition becomes more definitively metaphoric, a reference to a fantasy about a relationship.

It is universally agreed that the psychoanalytic conception of development has changed markedly from the conception assumed by Kohut when he depicted the clinical selfobject as archaic, narcissistically cathected, and prestructural. The view I shall present for this discussion derives from that presented in *Psychoanalysis and Infant Research* (Lichtenberg, 1983), Stern's (1985) *The Interpersonal World of the Infant*, and my (1989) *Psychoanalysis and Motivation*. After this survey of infant development, I will return to the definition of selfobject.

Let us consider first a scene of ordinary, smooth development—the kind of seamless passage of moments, hours, days, and months that lead parents to a memory that “Sally was a good baby.” It is late afternoon, and two-month-old Sally is asleep. Mrs. N, her dinner preparations completed, is reading a book and half-doing, too. Sally awakens with a start and cry and then dozes a moment. Mrs. N becomes alert, slowly but purposefully goes to get Sally's bottle, and responds with a reassuring “OK, honey” to Sally's now more sustained cry. Sally quiets some, and the feeding begins. Sally is a quick, hungry eater, and mother and baby concentrate on establishing this active sucking rhythm. Sally, temporarily sated, slows, stops, rolls her eyes up, and loosens her grasp on the bottle. Mrs. N simultaneously looks down, eye contact occurs, and a period of exchanges of smiling and vocalizing follows.

Sally frowns a second, and Mrs. N puts her to her shoulder to burp her. A second feeding period follows—slower and more mixed with play, as Sally touches the bottle and pulls at her mother's finger and blouse. The feeding completed, Mrs. N sits Sally on her lap, and they have a lively “conversation.” Sally's eyes are alert, she is gurgling, and her body

movements are in rhythm with the ups and downs of Mrs. N's melodic speech. A visit to the diapering table follows; Sally squeals with delight as she is tickled and cries angrily as she is restrained to get the diaper on. Mrs. N all the while is chattering, including such instructions as "Don't wiggle so" and "It will be over soon."

After the diapering, Sally is put in her crib on her back, and her musical mobile is started. Sally scans the mobile, follows its passage, and as the music runs down, frets. Mrs. N starts the music again three times and then notes that Sally is becoming drowsy. Sally's focus is now on her fingers, which she gets easily into her mouth, and she begins a slow, rhythmical sucking, her activity and alertness reduced. At this point, Mr. N enters with a shout of greeting, and Sally's whole body responds with jerky movements and responsive delight as she is swept up into the air, hugged, and kissed in one great flurry. This activity continues until tiredness overtakes Sally, who begins to fret and cry. Mr. N places Sally in Mrs. N's outstretched arms, and the mother begins to rock and soothe. Mrs. N places the quieted baby back in the crib, this time on her stomach. Sally places her fingers in her mouth and begins sucking, and Mrs. N gently taps her on the back in time with Sally's sucking. Sally drifts off to sleep with an occasional whimper.

Let us consider this ordinary scene from the standpoint of motivational systems. First, mother and infant are actively engaged in the regulation of the infant's physiological requirements. Sally has highly organized state changes, which in this example go from sleep, to crying, to alert attentiveness, to inactive awakeness, to highly active alertness, to crying, to drowsiness, to sleep. Besides state changes, mother and infant are involved in regulating feeding and elimination; father, mother, and infant are involved in regulating overall stimulus intensity and tactile and equilibrium stimuli.

Second, Sally in her seeking and responding to her mother and her father demonstrates her need for attachment and the pleasure of intimacy it evokes. Moreover, the scene illustrates that patterns of attachment, from earliest life, differ in form and intensity but have as their invariants exchanges of playful interaction and communication. Third, Sally, in her response to the mobile and the music box, demonstrates that when disengaged from attachment activities, she activated her need to explore her environment and assert her preferences. She could track the mobile and recognize the end of the music and signal her desire for its continuance. Fourth, she could actively signal her reaction of

aversiveness through antagonism and withdrawal. She could cry in hunger, pull away from the bottle when sated, push against something angrily when confined on the diaper table, indicate that she wanted the music restarted, and fret when overstimulated by her father's play. Fifth, she sought sensual enjoyment in sucking and in fondling her mother's hand and blouse. She showed delight in the excitement stirred up by her father and a calming pleasure from her mother's soothing and rocking and her own sucking.

There are then, in my view, five motivational systems. Each system is built around a basic need: the need for psychic regulation of physiological requirements, the need for attachment and later affiliation, the need for exploration and assertion, the need to react aversively through antagonism and/or withdrawal, and the need to seek sensual enjoyment and sexual excitement. Infants are born with innate programs in each system that allow them to be active partners coordinating with caregivers to respond to their basic needs. The innate programs all have a range of flexibility so that the caregivers' regulatory efforts quickly produce learned alterations. Within months the innate programs in each system, already modified by learning in response to caregiver interactions, are further modified as a consequence of infants' planning, intention, and hypothesis formation.

For perceptual-action patterns to attain psychological significance, they must trigger affective responses. The affective response amplifies the activity in each motivational system. The experiencing of affect, as perceptual-action patterns unfold, endows the event with the sense of familiarity, which makes its repetition a goal. Let us briefly consider some of the affects that are characteristic of each of the motivational systems:

1. The psychic regulation of physiological requirements—hunger distress leading to relief, passing to the pleasure of satiety, and stopping before the distress of being overstuffed; tiredness and drowsiness passing to the restorative feeling of sleep; bowel and bladder fullness passing to relief with expulsion; tactile pleasure from touching and being touched; equilibrium pleasure or distress from being held, moved, rocked, swung, and tossed; proprioceptive pleasure from movement and its coordination.
2. Attachment—the multiple pleasures of intimacy.
3. Exploration and assertion—the sense of being effective and the pleasure of competence.

4. Aversive reactions—anger, fear, shame, disgust, “dis-smell,” contempt.
5. Sensual enjoyment and sexual excitement.

To bring these somewhat abstract conceptions about early development closer to our consideration of the selfobject, we need to ask a thorny question: Does the baby “know” what he is experiencing when each of the motivational systems is dominant? Psychoanalytic theorists have always been wary of using behavior as the guide to psychological meaning. Freud’s concept of the reflex arc separated “mere” reflex from meaningful conscious and unconscious registry. Are the infant’s perceptual-affective-action patterns that unfold in coordination with caregiver ministrations “mere reflexes,” simple Pavlovian conditionings? How can we tell? The infant researchers have devised an imaginative set of experiments that strongly suggest that small infants do more than react superficially to their surround; these experiments demonstrate that infants both experience their world as having affective meaning and record that affective meaning in memory.

For example, mother’s approach to alert her infant sets off in the infant a pattern of facial expressions, eye focus, vocalizations, and bodily movements, all of which are part of greeting and social responses throughout life. Experimenters have had mothers alter their patterns to test the impact on the infants. Mothers are told to keep their faces immobile, and the infants respond by smiling and giving all their cues to start up their conversational game; then they become distressed and fretful, they avert their eyes, and their body slumps. Mothers are told to approach with their face natural but not to speak while a recording of another woman’s voice is played. The infants react with puzzlement and distress. Clearly the positive experience of pleasure in intimacy—triggered by these attachment behaviors—is more than a momentary reflex; it is a component of a pattern of expectancies that, when violated, leads to a switch of motivation to aversiveness.

Another example comes from experimental variations of exploratory-assertive responses. Infants are unexpectedly sensitive trackers of contingencies. By ingenious experimental contraptions, infants can learn that if they turn their heads a fixed number of times in a certain direction or kick their feet or suck at a certain rhythm, they can activate light or sound displays or set mobiles into motion. The interesting finding is that infants will maintain their interest far longer when they are the source of

the activation than if the display is set off for them. If the experiment is then altered so that the display is no longer triggered in a predictable sequence but is made to go off in random fashion, infants become irritable and withdraw. To summarize, observation and experimental research establish that infants develop expectations of intimacy pleasure from attachment activities and competence pleasure from exploratory-assertive activities. When their expectations are frustrated, when the patterns are interrupted externally, infants are aware of the disruption and react aversively. We need no extensive research to be convinced that similar effects occur if violations of expectancies occur in feeding, sleep, ranges of stimulus intensity, or the infants' patterns of sensual enjoyment.

Stern conducted observations and experiments that bear directly on my thesis about the selfobject. Stern observed that when infants engaged in activities such as shaking a rattle, crawling, and pushing a block back and forth, mothers made a body movement, vocalization, or facial expression that matched their infants in rhythm, intensity, and duration. During play interactions, these concrete evidences of attunement occurred every 65 seconds. The mothers' responses were intuitive; until the responses were demonstrated on videotapes, the mothers were unaware that they were responding to their baby in this attuned way.

Stern asked, Does this sharing have an impact on the infant? In comparison to activities of the mothers during which the impact can be observed, attunement responses appear to have no demonstrable effect. The infants continue to shake their rattles, crawl, or push their blocks. Stern had the mothers deliberately go out of phase and pretend to jiggle more slowly or rapidly. The infants noticed the discrepancy and stopped their activity. When the mother resumed, the infant resumed. Stern's experiment establishes that frequent, unnoticed, intuitive attunements convey the information to infants that their internal feeling states are shared with and responded to by the person or persons closest to them.

Obviously this attunement promotes attachment, but what other effect does it have? Stern reasoned that the caregiver's attunement responses influenced the infant's affective state. The infant shaking a rattle, crawling, or pushing a block had an affect state of interest and enjoyment; the mother's responses added to the interest and joy and increased their "vitality." Stern theorized that affect states cannot be adequately appreciated by recognizing the categorical emotion present—enjoyment, interest, anger, fear, sadness, shame, guilt, and so on—but

that affect states must include descriptors that take into account qualities of feeling such as surging, fading away, fleeting, explosive, crescendo, decrescendo, bursting, and drawn out. These he called "vitality" affects.

The vitality affects of crescendo and decrescendo are inextricably involved with all the essential processes of life—mounting hunger and getting fed and falling asleep and emerging out of sleep, as well as feeling the coming and going of all categorical emotions. From infancy on, all through life we experience qualities of rise and fall, surge and fade, both from our own activity and from the activities of others. How a mother picks up her baby, folds the diapers, runs her fingers through the baby's hair, moves toward or away—all these activities contribute to the quality of vitality present in the affective exchange. From the mother's facial and vocal expression and from a multitude of activities, a small infant will abstract general affective qualities such as liveliness, the slowing down that occurs during depression, the jerky tension of anger bursts, the soothing down of comforting, or the persistent modulating of a calm unruffledness. Similarly, therapists convey more than cognitive understanding to the quality of the therapeutic exchange. Through our lively interest and tempered concern or through our apathetic indifference, ritualized correctness, or restrained irritability, we influence the vitality present in any categoric affect—pleasurable or dystonic, as well as the therapeutic ambience as a whole.

Stern's observations of the vitalizing effect of attunement between mother and infant could be used to support Kohut's conception of a selfobject as neither self nor separate, whose positive effect on cohesion arises from the selfobject's availability for merger. Stern and I both believe the overwhelming evidence from other findings points to the conclusion that self with other involves intimacy but not merger. Stern posited that since the observational and experimental research indicates that infants experience agency and volition, body coherence as locus, affective coherence as a source of awareness, and continuity of experience in the form of memory buildup, the infant must be considered as capable of differentiation of self. Thus infants do not begin life as fused or merged with their mothers in a state of undifferentiation, from which they only gradually emerge over the first year or more. The differentiation of self in infancy differs from the differentiation evident in later experiences of subtle identifications and the formation of fantasies of entering and leaving merger states.

To appreciate the differentiation of self during infancy, let us recon-

sider the impact of his mother's attunement responses on the infant who is shaking a rattle, crawling, or pushing a block. First, the infant is experiencing agency and volition. The crescendo or decrescendo and the surge or fade of his own activity will influence his vitality. Second, the mother's attunement will add to that vitality and thus enhance the sense of agency and volition without creating a loss of boundaries or of differentiation of self. Further, in each attunement experience during direct attachment play, infants initiate fully half of the responses and exercise considerable control over the patterning. Differentiation is enhanced, not lost. Not merger, but a combination of having needs met and being vitalized by attunement responses triggers selfobject experiences that strengthen the core self.

The point of this review of infant studies is that, while Kohut's clinical discovery remains poignantly compelling, the theory of development he based it on and the terms he used to describe it require reconsideration.

Internalized Function or Vitalizing Experience? Selfobject or Selfobject Experience?

Assumption 3. Shifting emphasis to a selfobject experience raises new questions about the nature of that experience. Viewed clinically, the core feature of the experience lies in the restoration of cohesion and vitality of the self. Viewed developmentally, the core feature of the experience lies in the attunement of caregivers to the infant's motivational needs and the vitality of the intimacy this affords. Intimacy and the affects that arise from attunement to needs and wishes in any of the motivational systems are in Wolf's (1990, personal communication) words "instrumental in bringing about the wonderfully blissful experience of BEING, of experiencing oneself as a person, a self, in other words, the bliss of a self being evoked via a selfobject experience." Restoration in the clinical setting is relatively dramatic; attunement in normal development occurs with relatively little notice, the vitalizing occurring as an accompaniment to ordinary responses to needs.

We have now considered evidence from two sources: clinical psychoanalysis and infant research. From the clinical findings we conclude that when patients experience a threat to self-cohesion, they require our understanding of the source of their altered state of self. We need to

recognize their sense that a sustaining experience of being affirmed or included in an alterego or idealized sharing has been disrupted. When the understanding occurs, the sustaining experience is reconstituted, self-cohesion is restored, and a tiny advance in self-solidity will have occurred. From the infant studies, we conclude that infants gain self-functional capacity through the exercise of motives in five motivational systems. The experiential meaning of the exercise of innate and learned patterns derives from affects triggered by the perceptual-action patterns. The affects of infants and caregivers are both categoric and something more—the presence or absence of a vitalizing quality. Each affectively meaningful lived experience is remembered as a generalized version of repeated episodes of self interacting with others. Small variations in each subsequent lived experience lead to adjustments in the responses and the memories, hopefully adding to both the functional range and the vitality of the self.

The common thread between these two sources is the significance of affective experience. With this in mind let us reconsider Kohut's (1971) definition:

Some of the most intense narcissistic experiences relate to objects; objects, that is, which are either used in the service of the self and of the maintenance of its instinctual investment, or objects which are themselves experienced as part of the self. I shall refer to the latter as *self-objects* [p. xiv].

A restatement might be that some of the most intense experiences involving one's sense of self are triggered by the empathic responsiveness of others. When empathic responsiveness ensures an experience of cohesion and vitality of the self, we designate it as a selfobject experience.

The shift to experience has two virtues to recommend it. First, the central core of the self-psychological approach lies in its emphasis on an empathic mode of perception, and selfobject experiences are appreciated empathically. Second, selfobject experiences fit into the theoretical perspective of self psychology's current emphasis on the intersubjective world of the therapeutic exchange (Stolorow et al., 1987) and away from holdover conceptions of archaic merger states, archaic fantasies of omnipotence, and mechanistic lists of ego functions and qualities of energy (narcissistic libido).

Still, problems remain. How do we recognize empathically and introspectively a selfobject experience? What is the source of the experience? A patient enters analysis in a state of distress. Gradually she feels intact, more herself. She feels understood, her good intentions appreciated, her failures sympathized with, her accomplishments affirmed and admired. She is having a selfobject experience. But from whose point of view? Hers! Her view may well be shared empathically by her analyst, although introspectively the analyst probably has some degree of divergence—less confidence in his understanding, less sympathy for her failures, maybe even a touch of envy for her accomplishments. Now, at some point, the analyst speaks when the patient wants only to be heard, or the analyst does not reassure, advise, admire, argue with, explain, or indicate affective attunement when the patient feels she needs that response. The patient's state of mind undergoes a radical shift. She feels depleted, irritable, wounded, humiliated, spiteful, withdrawn, apathetic. She has suffered an empathic failure from the analyst. From whose point of view? Hers! The analyst (or an external observer) may recognize no disturbance in the analyst's attentiveness and resonance.

Technically the analyst's task is then to investigate the patient's experience of his committing an empathic failure, for example, how she heard him move in his chair "disgustedly." Maybe he will or will not find the disgust. If he does, he must own up to it and understand it internally, but for the immediate exploration it may be beside the point. The nature, form, context, and intensity of the disgust need to be investigated as she experienced them. Since the disgust triggered the loss of a selfobject experience of being approved of, this exchange must bring about a sense of shared understanding about the loss and its trigger to provide an optimal opportunity for the restoration of a selfobject experience.

For contrast, let us now consider another clinical situation. On another day, the patient is experiencing herself approved of, the analyst moves in his chair, and she exclaims, "I hate it when I hear you move. It makes me worried that you are having a bad thought about me. It reminds me of my father at the dinner table getting restless if I took too long telling him something that happened to me." No depletion, humiliation, or the like at the hands of the analyst—only an intact self talking about a concern recognized as based on a lived experience of a past empathic failure. At another time the analyst offers an interpretation that turns out from both the patient's and the analyst's perspective to be

faulty, and no vulnerability of the self is triggered by the misunderstanding. It is an empathic failure but, to use the phrase of Stolorow et al. (1987), not a selfobject failure.

We are ready to draw our first conclusion: in the clinical situation, a selfobject experience implies the existence of mental contents comprising an intact or restored, affectively invigorated sense of self; an affirming, and/or like-minded, and/or idealized other; and whatever else a dominant motivation calls for. A selfobject experience is thus a reference not to actual interpersonal relations or to internalization of functions but to an affect-laden symbolic representation. And the specific relationship between self and affirming, like-minded, or idealized other—that of part self, part other—is itself a symbolic representation bearing the stamp of fantasy and metaphoric expression. Consequently, when, as therapists, we consider our contribution to helping patients create or restore a selfobject experience, we must think of ourselves not as the individuals we are but as the metaphor (symbolic representation) the patients form of us in their psyche.

Does centering our focus on the patient's view of us depreciate the importance of what we actually do? Not at all. Just the opposite. As Stolorow et al. (1987) state, "Once an analyst has grasped the idea that his responsiveness can be experienced subjectively as a vital, functional component of a patient's self-organization, he will never listen to analytic material in quite the same way" (p. 17). As was true of good analytic practice before self psychology, the analyst will listen empathically to all the patient's associations to understand their meaning from the patient's perspective. But, because of the contribution of self psychology, the analyst will, in addition, listen empathically to all the patient's associations to sense the presence or absence, waxing or waning of himself as contributor to the patient's self-cohesion from the patient's perspective. Thus, as therapists, we are relieved of trying to be selfobjects. We can only be therapists. But as therapists our skill is crucial in whether the patient can create, from the intersubjective immersion of our shared exchanges, selfobject experiences.

We must utilize our skills in three ways. First, by establishing the framework of the treatment through our consistency, reliability, caring, concern, and essential friendliness, we establish a therapeutic ambience. Second, through our persistent capacity to understand the full range of the patient's motivations, we institute an empathic immersion into the

patient's world of wishes, aims, beliefs, values, conflicts, and torments. Third, through our persistent effort to track the patient's sense of self, we institute an empathic immersion into the patient's world of resilience to or vulnerability to loss of self-cohesion and depletion of self. Thus in the clinical situation, by doing the ordinary work that promotes restoration of self (self-righting) and the reorganization of symbolic representations, the optimally responsive (Bacal, 1985) therapist triggers *pari passu* self-object experiences.

In infancy, the definition of a selfobject experience as a fantasy or metaphoric expression in which the self is experienced as being completed by another cannot be applied because symbolic representations of this type in all probability do not occur before 18 months. Self engaged with other in attachment activities, self disengaged from other in exploratory activities, self engaged with other in numerous activities of physiological regulation, self aversive to other, and self engaged with other and with self in seeking sensual enjoyment are all lived experiences. In these lived experiences the self as represented in perception during an event and in memory afterward is commonly separate and distinct, the representations of self and others being generalized from prior lived experiences (Stern, 1985; Lichtenberg, 1989). The affect that is triggered in the course of these activities, rather than a sense of the self being completed by a caregiver, is crucial to their psychological meaning. Later, after 18 months, symbolic alteration through primary and secondary process modes provides a plastic associative molding to events and the people in them as well as a lively world of fantasy and imagination. Then we can properly speak of a selfobject as a metaphor or fantasy for part self, part object. Still, the affective experience provides a major link assuring continuity in motivation between the presymbolic and the postsymbolic periods.

Each infant and the matrix of caregivers with whom he develops a sense of self and systems of motivation provide a unique challenge to create a fit that triggers not only a full range of categoric affects but also the particular "value-added" experiences of affect crescendo and decrescendo that give vitality to the exchanges. Thus, caregivers cannot be selfobjects to children; they can only be mothers and fathers taking part in the complex exchanges of lived experiences. But their capacity for "affect attunement leads to a shared world. . . . If affect attunement is not present or is ineffective during [the] early years, the lack of shared

experience may well create a sense of isolation and a belief that one's affective needs generally are somehow unacceptable and shameful" (Basch, 1985, p. 35).

Attunement must not be thought of as limited to a few types of attachment experiences; it involves a wide variety of responsiveness to the different needs of each motivational system for selfobject experiences to be triggered. The recurrent nature of the need for caregivers to restore comfort and satisfaction after physiological distress of hunger and the like, to engage in intimacy pleasure, to facilitate the enjoyment of competence in exploration and assertion, to recognize accurately signals of aversion, and to participate in and affirm the infant's seeking of sensual enjoyment provides ample opportunities for selfobject experiences to be enjoyed by both infant and caregivers. The triggering selfobject may be many, many "things"—a satisfying feeding, a shared look, a hand that plays pat-a-cake, a mobile that captures attention, a burst of anger that makes a frustrated effort at assertion work, a blanket that soothes—all depending on whether included in the experience is a vitality of affect that heightens and enriches its meaning. This broadened view of motivation during intimacy portrays the selfobject trigger and the selfobject experience of normal development in the presymbolic period.

Abnormal Development and Selfobject Experiences

Assumption 4. In ordinary development a reservoir of selfobject experiences forms as a consequence of needs being met and signals of distress being responded to. The affects during these recurrent moments range from the quiet satisfactions of intimacy, efficacy, and sensual enjoyment and the sense of security as distress is relieved to the more lively, exuberant moments of active social play, novel toy encounters, and sexual excitement. Inevitably every child will experience heightened dystonic moments of physical distress, minor injury, interactive anger and fear, task frustration, and sexual confusion and overstimulation. In ordinary development, the child will respond to these dystonic moments by searching for someone or something that will trigger selfobject experiences that affirm self-cohesion and vitality. If, however, the consistent, lived experience of the individual is that needs have not been met in any motivational system, the individual will seek satisfaction, joy, a

sense of security, relief of distress, self-cohesion, and vitality through alternative experiences. The many patterns of activities that comprise the functioning of each motivational system provide ample opportunity for intense, lived experiences in which the affects may be pleasurable but the consequences maladaptive (excited crayoning all over a newly painted wall with a spanking to follow), or the affects may be unpleasurable (having one's arm twisted in a wrestling match). When needs are generally met, these lived experiences may have relatively few consequences. When needs are not met, these intense alternative experiences can come to be desired. The individual will then create and re-create comparable situations and thus gain affect-intense experiences along with an immediate, reassuring sense of familiarity and control despite long-range maladaptive results.

The assumption that the effect of abnormal or variant development is to seek selfobject experiences through means other than ordinary responses to ordinary needs is, I believe, compatible with the self psychology view of the genesis of psychopathology. This view states that while pathology often results from what has been done to the developing child in the form of neglect, abuse, and traumatic events, the experience of these happenings centers on what has failed to be done in the form of empathic responsiveness to the child's needs. Where self psychology has often spoken of caregiver failures in empathic responsiveness as producing deficits in the development of self "structures," I am speaking of a deficit in vitalizing selfobject experiences from ordinary sources: the pleasure of satiety from oral intake, of relief from elimination, and of restoration from sleep; the multiple satisfactions of intimacy; the sense of efficacy and competence pleasure from exploration and assertion; the effective use of antagonism and avoidance; and the enjoyment of sensuality and sexual excitement.

When a deficit of affective vitalization from ordinary sources occurs, three conditions may be responsible for children or adults discovering that they experience and seek vitality and cohesion from maladaptive, perverse, or pathologic sources.

First, the repetition of experiences of a traumatic or abusive nature may have a strong organizing effect because of the intensity of the experience. Where physical pain has been a recurrent experience, it may create a more cohesive experience than comfort. Where humiliation or guilt has been a recurrent experience (Weiss and Sampson, 1986), these negatively toned affects may convey more intensity of an intimate

relationship than respect or an uncomplicated assumption of responsibility. Similarly, the numbing confusion and bad self feeling of repeated failures in exploration and assertion, especially those that may accompany learning disabilities, may become more familiar cohesive states than occasional bursts of competence pleasure. Anger, especially tantrumlike destructive rages, may be sought for temporary vitalization; extended states of hatred and of the pursuit of vengeance may be resorted to for long-term contributions to self-cohesion. Sexual excitement states, often divorced from intimacy, may be sought, with or without accompanying states of degradation, for the temporary exuberance of the experience. Neurophysiologically, this hypothesis is supported by findings that suggest that while "maternal contact comfort stimulates a brain endorphin reward system" with "addictive-like qualities" to normal maternal behavior, both good and bad encounters "mobilize the endorphin-enkephalin-attachment system and can account for the tenacity of attachment to an abusing parent" (Hadley, 1989).

A second source of pathological selfobject experience may arise from those objects or substances that can serve as a means to provide comfort or relief from a wide range of discomforts and dystonic experiences. The mother's hand to hold and finger to suck, the pacifier, and the transitional object are the normal prototypes for later, more problematic activities, objects, or substances. These activities, objects, or substances do not deal directly with the specific source of the discomfort, as would food and hunger, a lively toy with boredom, or a playmate with loneliness. These substances, activities, and objects have a hedonic and regulatory effect in their own right because of their inherent triggering of affects. One group of activities triggers affects through either the calming or the stimulation of sensual pleasure, as when a child in a state of loneliness, boredom, uncertainty, hyperactivity, or generalized excitement will reach for his genital. Other activities that become available as inherent triggers of affect are risk taking such as gambling, the multiple stimulating and calming effects of smoking, and the whole range of effects of drugs, drinking, and toxic substance usage (Ulman and Paul, 1988). The great significance of these activities, objects, or substances lies in their providing relief not for one specific need but for a panoply of present or potential distress and discomforts. Threats of the unavailability of the multipurpose relief or security giver become a major source of distress, sometimes far greater than would be the distress of the primary source of discomfort. Once a child has come to rely on a cuddly for

comfort regardless of the source of distress, the expectation of a period of hunger, mother's absence, the unavailability of toys, or being punished will often not evoke the kind of alarm that the loss of the cuddly triggers. Similarly a habitual smoker may be able to bear a sleepless night without snack, spouse, or book but be driven to find an open convenience store on discovering he has run out of cigarettes (Tomkins, 1989, personal communication). Similar to a toddler's use of his security blanket, the utilization and reliance on any age-appropriate means to obtain a selfobject experience that relieves a multitude of possible discomforts are not pathologic in themselves. They become pathologic when obtaining and preserving the activities, objects, or substance become a central focus of the person's motivation. The sources of discomfort are not then subjected to recognition and a search for solution. The goal has become to assure the availability of the means to obtain the relief; the addictive demand is for the activity (being repeatedly reassured, the gambling casino), the object (the person of the analyst, the fast car, the jewel), or the substance (cigarettes, alcohol, cocaine). Neurophysiologically, the same pleasure-reward pathways and chemicals once triggered can serve to provide selfobject experiences indiscriminately.

A third source of selfobject experiences derives from ideation associated with experiences that provide a powerful boost to vitalization and cohesion of the self. A child's belief that she is a beautiful, loved little girl is never separate from actions—her parents and her own—but it is the "illusion" that can trigger the selfobject experience with or without an action pattern. Religion utilizes this recognition in its promise of an enduringly available, protective deity. Reliance on a conscious belief or a preconscious or largely unconscious fantasy system as a source of selfobject experience to relieve distress and raise self-esteem is not pathological, although the beliefs and fantasies and their enactments may be maladaptive. The illusion assumes pathologic consequences if an individual is unwilling to recognize that it is serving as a means to create an affect state of invigoration or cohesion that might otherwise be lacking. For example, a Don Juan fantasy does not assume pathologic consequences because the person gains social ease or phallic invigoration or heightened potency and orgasmic excitement from it. The main pathologic consequence arises if the individual cannot recognize that he resorts to the fantasy (and attendant behavior) as a means to relieve unrecognized distress from a variety of sources that may arise from problems in any motivational system, not necessarily the sensual-sexual

system. As long as the person's dominant motivation is to preserve the fantasy and resist every effort to create doubt about its validity or its compatibility with other goals, little attention can be given to the actual sources of distress. From the person's point of view, distress arises from the threat to dislodge the belief or illusion or unconscious fantasy that has become the source of a vitalizing experience he relies on to cope with stress from a variety of sources. Omnipotence and overidealization are frequent fantasy elaborations used in this way as a means to create illusory but consistently re-creatable selfobject experiences, however brief and vulnerable. For patients whom we are able to help in analysis, a strong desire for sustainable selfobject experiences from more ordinary sources persists alongside of the addictive search for alternate triggers recognized to be maladaptive.

Summary

"Selfobject" as a term designates that which triggers a selfobject experience. In the clinical situation, the analyst's restored empathic understanding, experienced as mirroring, like-minded, or idealized, provides the trigger. In normal development, affectively attuned caregivers, specific objects (food, toy, blanket), and self-activity may provide the trigger. In abnormal development and in pathological states, the excitement of being hurt, the excitement of hurting others, mood-altering drugs, sexually aberrant situations, body state-altering experiences, risk taking, and idealized cults may provide the trigger. Thus selfobject is a term that lacks specificity unless its use is restricted to the intersubjective experience of an ongoing exploratory therapy. "Selfobject experience" designates an affective state of vitality and invigoration, of needs being met, and of intactness of self. Selfobject experience can be triggered undramatically in the course of having ordinary needs met and more dramatically where an unmet need state has threatened self-cohesion. When self-cohesion is threatened, the selfobject experience may be associated with triggering stimuli that adaptively affirm and enhance the initiating, organizing, and integrating capacities of the self. Alternatively, when self-cohesion is threatened, the selfobject experience may be associated with less adaptive triggering stimuli that provide only a temporary mood alteration. The triggering stimuli for selfobject experi-

ences that only temporarily alter mood often weaken the initiating, organizing, and integrating capacities of the self and lead to an additive desperation to hold onto a pattern of behavior that (1) repeats an early, pathologic lived experience, (2) involves an object, person, or substance that comes to serve as an all-purpose source of enlivening or soothing, and/or (3) involves a fantasy that serves similarly to enliven or soothe regardless of the basic source of the deficiency or conflict.

References

- Bacal, H. (1985), Optimal responsiveness and the therapeutic process. In: *Progress in Self Psychology*, Vol. 1, ed. A. Goldberg. New York: Guilford Press, pp. 202–227.
- Basch, M. F. (1985), Selfobjects and selfobject transference: Theoretical implications. In: *Kohut's Legacy*, ed. P. E. Stepansky & A. Goldberg. Hillsdale, NJ: The Analytic Press, pp. 21–41.
- Freud, S. (1917), Mourning and melancholia. *Standard Edition*, 14:237–258. London: Hogarth Press, 1957.
- Goldberg, A. (1989), *A Fresh Look at Psychoanalysis: The View from Self Psychology*. Hillsdale, NJ: The Analytic Press.
- Hadley, J. (1989), The neurobiology of motivational systems. In: *Psychoanalysis and Motivation*, by J. Lichtenberg. Hillsdale, NJ: The Analytic Press, pp. 337–372.
- Kohut, H. (1971), *The Analysis of the Self*. New York: International Universities Press.
- _____ (1977), *The Restoration of the Self*. New York: International Universities Press.
- _____ (1984), *How Does Analysis Cure?* ed. A. Goldberg & P. Stepansky. Chicago: University of Chicago Press.
- Lichtenberg, J. (1983), *Psychoanalysis and Infant Research*. Hillsdale, NJ: The Analytic Press.
- _____ (1989), *Psychoanalysis and Motivation*. Hillsdale, NJ: The Analytic Press.
- Stern, D. (1985), *The Interpersonal World of the Infant*. New York: Basic Books.
- Stolorow, R. (1986), Critical reflections on the theory of self psychology: An inside view. *Psychoanal. Inq.*, 6:387–402.
- Stolorow, R., Brandchaft, B. & Atwood, G. (1987), *Psychoanalytic Treatment: An Intersubjective Approach*. Hillsdale, NJ: The Analytic Press.
- Ulman, R. & Paul, H. (1988), The addictive personality disorder and addictive trigger mechanisms. Presented at the Eleventh Annual Conference of the Psychology of the Self, Washington, DC, Oct. 13–16, 1988.
- Weiss, J. & Sampson, H. (1986), *The Psychoanalytic Process*. New York: Guilford Press.
- Wolf, E. (1988), *Treating the Self: Elements of Clinical Self Psychology*. New York: Guilford Press.