Affects and Selfobjects

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Selfobject—the central, foundational construct in the psychoanalytic psychology of the self—can be defined phenomenologically as an object that a person experiences as incompletely separated from himself and that serves to maintain his sense of self (Kohut, 1971, 1977). We perceive this concept to be vulnerable to two maladies that can afflict important theoretical ideas in the early phases of their evolution. On the one hand, there is a tendency for the concept to remain unduly static and narrow, restricted to the particular idealizing and mirroring ties delineated by its originator. On the other hand, in the enthusiasm of theoretical expansion, there is the danger of the concept becoming overly general and imprecise, as when it is extended to encompass almost any caregiving activity that a child or developmentally arrested adult may require. Our intention in the present paper is to offer an expansion and refinement of the selfobject concept that we believe can skirt both the Scylla of theoretical encrustation and the Charybdis of overgeneralization. It is our contention that selfobject functions pertain fundamentally to the integration of affect, and that the need for selfobjects ① pertains most centrally to the need for phase-appropriate responsiveness to affect states in all stages of the life cycle. To develop this claim we must first examine briefly the pivotal role of affect and affect integration in the structuralization of the self.

We conceive of the self as an organization of experience, referring specifically to the structure of a person’s experience of himself (Atwood and Stolorow, 1984, chap. 1). The self, from this vantage point, is a psychological structure through which self-experience acquires cohesion and continuity.

① Here and elsewhere, when we use the term “selfobject” we refer to an object experienced subjectively as serving selfobject functions.

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and by virtue of which self-experience assumes its characteristic shape and enduring organization. The fundamental role of affectivity in the organization of self-experience has been alluded to by generations of analytic investigators and has found considerable confirmation in recent studies of the patterning of early infant-caregiver interactions (see Lichtenberg, 1983; and Basch, 1984). Defining the self as a structure of experience, therefore, brings the central importance of affect integration in its evolution and consolidation into particularly bold relief.

Affects can be seen as organizers of self-experience throughout development, if met with the requisite affirming, accepting, differentiating, synthesizing, and containing responses from caregivers. An absence of steady, attuned responsiveness to the child's affect states leads to minute but significant derailments of optimal affect integration and to a propensity to dissociate or disavow affective reactions because they threaten the precarious structuralizations that have been achieved. The child, in other words, becomes vulnerable to self-fragmentation because his affect states have not been met with the requisite responsiveness from the caregiving surround and thus cannot become integrated into the organization of his self-experience. Defenses against affect then become necessary to preserve the integrity of a brittle self-structure.

It is the thesis of this paper that selfobject functions pertain fundamentally to the affective dimension of self-experience, and that the need for selfobjects pertains to the need for specific, requisite responsiveness to varying affect states throughout development. Kohut’s (1971, 1977) conceptualizations of mirroring and idealized selfobjects can be viewed as very important special instances of this expanded concept of selfobject functions in terms of the integration of affect. His discovery of the developmental importance of phase-appropriate mirroring of grandiose-exhibitionistic experiences points, from our perspective, to the critical role of selfobject responsiveness in the integration of affect states involving pride, expansiveness, efficacy, and pleasurable excitement. As Kohut has shown, the integration of such affect states is crucial for the consolidation of self-esteem and self-confident ambition. The importance of early experiences of oneness with idealized sources of strength, security, and calm, on the other hand, indicates the central role of soothing, comforting responses from selfobjects in the integration of affect states involving anxiety, vulnerability, and distress. As also shown by Kohut, such integration is of great importance in the development of self-soothing capacities which, in turn, contribute vitally to one's anxiety tolerance and over-all sense of well-being.

Kohut (1977) seemed himself to be moving toward a broadened selfobject concept in his discussion of two ways in which parents can respond to the affect states characteristic of the oedipal phase:

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The affectionate desire and the assertive-competitive rivalry of the oedipal child will be responded to by normally empathic parents in two ways. The parents will react to the sexual desires and to the competitive rivalry of the child by becoming sexually stimulated and counteraggressive, and, at the same time, they will react with joy and pride to the child's developmental achievement, to his vigor and assertiveness [p. 230].

Whether the oedipal period will be growth enhancing or pathogenic will depend on the balance that the child experiences between these two modes of parental response to his oedipal feelings:

If the little boy, for example, feels that his father looks upon him proudly as a chip off the old block and allows him to merge with him and with his adult greatness, then his oedipal phase will be a decisive step in self-consolidation and self-formation, including the laying down of one of the several variants of integrated maleness. ... If, however, this aspect of the parental echo is absent during the oedipal phase, the child's oedipal conflicts will, even in the absence of grossly distorted parental responses to the child's libidinal and aggressive strivings, take on a malignant quality. Distorted parental responses are, moreover, also likely to occur under these circumstances. Parents who are not able to establish empathic contact with the developing self of the child will, in other words, tend to see the constituents of the child's oedipal aspirations in isolation—they will tend to see ... alarming sexuality and alarming hostility in the child instead of larger configurations of assertive affection and assertive competition—with the result that the child's oedipal conflicts will become intensified [pp. 234-235].

In these quotations Kohut not only emphasizes the importance of parental responsiveness to oedipal-phase affectionate and rivalrous feelings; in addition, by focusing on affectionate and rivalrous feelings he expands the affective domain requiring responses from selfobjects considerably beyond that which is implicit in his earlier, more delimited formulations of mirroring and idealizing selfobject ties.

Basch (1983), in a discussion of the earlier, sensorimotor phase, advances an argument closely similar to ours by expanding Kohut's (1971) original concept of mirror function as pertaining to archaic grandiosity to encompass broad areas of "affective mirroring." Drawing on the work of Stern (1983), he writes:

Through affective attunement the mother is serving as the quintessential selfobject for her baby, sharing the infant's experience, confirming it in its activity, and building a sensorimotor model for what will become its self concept. Affect attunement leads to a shared world; without affect attunement one's activities are solitary, private and idiosyncratic. ...

[If... affect attunement is not present or is ineffective during those 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 [pp. 5-6].

Basch views the defenses that appear in treatment as resistances against affect originating in an absence of early affect attunement.

We now wish to extend the expanded concept of selfobject functions to certain other aspects of affect development that we believe are central to the structuralization of self-experience. These include: (1) affect differentiation and its relationship to self-boundary formation; (2) the synthesis of affectively discrepant experiences; (3) the development of affect tolerance and the capacity to use affects as self-signals; and (4) the desomatization and cognitive articulation of affect states.

**Affect Differentiation and Self-articulation**

Krystal (1974), who has been most comprehensive in applying a psychoanalytic developmental perspective to affect theory, has pointed out that an important component in the developmental transformation of affects "involves their separation and differentiation from a common matrix" (p. 98). He has emphasized as well the critical importance of the mother's responsiveness in helping the child to perceive and differentiate his varying affect states. What we wish to emphasize here is that this early affect-differentiating attunement to the small child's inchoate feeling states contributes vitally to the progressive articulation of his self-experience. Such differentiating responsiveness to the child's affects, therefore, constitutes a central selfobject function of the caregiving surround, in establishing the earliest rudiments of self-definition and self-boundary formation.
The earliest processes of self-demarcation and individualization thus require the presence of a selfobject who, by virtue of a firmly structured sense of self and other, is able reliably to recognize, distinguish, and respond appropriately to the child's distinctive affect states. When a parent cannot discriminate and respond appropriately to feeling states of the child—for example, when those states conflict with a need for the child to serve the parent's own selfobject needs—then the child will experience severe derailments of his self-development. In particular, such situations will seriously obstruct the process of self-boundary formation, as the child feels compelled to “become” the selfobject that the parent requires (Miller, 1979)

2 Basch notes that, as early as 1915, Freud, too, had expressed the belief that defense was always against affect.

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and thus to subjugate or dissociate central affective qualities of his own that conflict with this requirement (see Atwood and Stolorow, 1984, chap. 3, for a detailed clinical illustration).

The Synthesis of Affectively Discrepant Experiences

A second critical selfobject function of the early caregiving surround concerns the child's synthesis of contradictory affective experiences, a process vital to the establishment of an integrated sense of self. These early affect-synthesizing processes require the presence of a selfobject who, by virtue of firmly integrated perceptions, is able reliably to accept, tolerate, comprehend, and eventually render intelligible the child's intense, contradictory affect states as issuing from a unitary, continuous self. When a parent, in contrast, must perceive the child as “split”—for example, into one being whose “good” affects meet the selfobject needs of the parent and a second, alien being whose “bad” affects frustrate those needs—then the development of the child's affect-synthesizing capacity and the corresponding advance toward integrated selfhood will be severely obstructed, as affectively discrepant experiences become enduringly sequestered from one another in conformity with the parent's fragmentary perceptions (see Atwood and Stolorow, 1984, chap. 3, for clinical illustration).

Affect Tolerance and the Use of Affects as Self-signals

Closely related to the role of early selfobjects in the processes of affect differentiation and synthesis and the corresponding differentiations and syntheses of self-experience is the contribution of the early caregiving surround to the development of affect tolerance and the capacity to use affects as signals to oneself (Krystal, 1974, 1975). These developmental attainments, too, require the presence of a selfobject who can reliably distinguish, tolerate, and respond appropriately to the child's intense, shifting affective states. It is the caregiver's responsiveness that gradually makes possible the modulation, gradation, and containment of strong affect, a selfobject function alluded to in the concept of the parent as a “stimulus barrier” or “protective shield” against psychic trauma (Krystal, 1978), in Winnicott's (1965) notion of the “holding environment,” and in Bion's (1977) evocative metaphor of the container and the contained. This modulation and containment of affects make possible their use as self-signals. Rather than traumatically rupturing the continuity of self-experience, affects can thereby become employed in the service of its preservation.

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The primary caregiver, as selfobject, must assist the child in comprehending and interpreting his constantly shifting and evolving emotional experiences. Through countless experiences throughout early development, the caregiver, by interpreting, accepting, and responding empathically to the child's unique and separate feeling states, is at the same time enabling him to monitor, articulate, and understandingly respond to them on his own. When the caregiver is able to perform this important selfobject function by way of using her own affect-signalizing capacity, a process of internalization occurs, culminating in the child's ability to use his own emotional reactions as self-signals (see Tolpin, 1971, and Krystal, 1974, 1975). When affects are perceived as signals of a changing self-state rather than as indicators of impending psychological disorganization and fragmentation, the child is able to tolerate his emotional reactions without experiencing them as traumatic. Thus some rudimentary capacity to use affects as self-signals is an important component of the capacity to tolerate disruptive feelings when they emerge. Without this self-signalizing capacity, affects tend to herald traumatic states (Krystal, 1978) and are thus disavowed, dissociated, repressed, or encapsulated through concrete behavioral enactments, self-protective efforts that literally cut off whole sectors of the child's affective life. In such cases, the emergence of affect often evokes painful experiences of shame and self-hatred, arising originally from the absence of positive, affirming responsiveness to the child's feelings. Emotionality thereby becomes linked with a solitary and unacceptable state that must somehow be eliminated. Trauma is viewed here not as an event or series of events overwhelming an ill-equipped “psychic apparatus.” Rather, the tendency for
affective experiences to create a disorganized (i.e., traumatic) self-state is seen to originate from early faulty selfobject attunement, with a lack of mutual sharing and acceptance of affect states, leading to impaired affect tolerance and an inability to use affects as self-signals.

The Desomatization and Cognitive Articulation of Affect

Krystal (1974, 1975) has stressed that an important dimension of affect development (and we would add, of self development) is the evolution of affects from their early form as predominantly somatic states into experiences that can gradually be verbally articulated. He also emphasizes the role of the caregiver's ability to identify correctly and verbalize the child's early affects in contributing to this developmental process. In our view, the importance of empathically attuned verbal articulation is not merely that it helps the child put his feelings into words; more fundamentally, it gradually facilitates the integration of affective states into cognitive-affective schemata—psychological structures that, in turn, contribute significantly to the organization and consolidation of the self. The caregiver's verbal articulations of the child's initially inchoate, somatically experienced affects thus serve a vital selfobject function in promoting the structuralization of self-experience.

The persistence of psychosomatic states and disorders in adults may be seen as remnants of arrests in this aspect of affective and self development. When there is an expectation that more advanced, cognitively elaborated organizations of affective experience will not be met with the requisite responsiveness, replicating the faulty affect attunement of the childhood surround, the person may revert to more archaic, somatic modes of affect expression in the unconscious hope of thereby evoking the needed responses from selfobjects. Such psychosomatic states thus represent an archaic, presymbolic pathway of affect expression through which the person unconsciously attempts to establish a tie to a selfobject required for affect containment and thus for the maintenance of self-integrity. In the psychoanalytic situation we regularly observe that when the analyst becomes established as an affect-articulating and containing selfobject, the psychosomatic symptoms tend to recede or disappear, only to recur or intensify when the selfobject tie becomes disrupted or when the patient's confidence in the analyst's receptivity to his affects becomes significantly shaken.

Implications for Psychoanalytic Therapy

Two major therapeutic implications follow from our expanded concept of selfobject functions as pertaining to the integration of affect, and from our corresponding emphasis on the fundamental importance for the structuralization of the self of the responsiveness of the early caregiving surround to the child's emerging affect states. One implication concerns the analytic approach to defenses against affects when these emerge as resistances in the course of psychoanalytic treatment. As we have stressed, the need to disavow, dissociate, or otherwise defensively encapsulate affect arises originally in consequence of the failure of the early selfobject milieu to provide the requisite, phase-appropriate attunement and responsiveness to the child's emotional states. When such defenses against affect arise in treatment, they must be understood as being rooted in the patient's expectation or fear in the transference that his emerging feeling states will meet with the same faulty responsiveness that they received from the original caregivers. Furthermore, these resistances against affect cannot be interpreted as resulting solely from intrapsychic processes within the patient. Such resistances are most often evoked by events occurring within the analytic situation which for the patient signal a lack of receptivity on the analyst's part to the patient's emerging feeling states and which therefore herald a traumatic recurrence of early selfobject failure.

A second therapeutic implication of our thesis concerning affects and selfobjects is that once the transference resistances against affect based on the "dread to repeat" (Ornstein, 1974) the damaging childhood experiences have been sufficiently analyzed (in the context of "good-enough" affective attunement on the part of the analyst), the patient's arrested developmental need for the originally absent or faulty responsiveness to his emerging affect states will be revived with the analyst. The specific emotional states involved and the specific functions that the patient requires the analyst to serve in relation to these states will determine the particular features of the unfolding selfobject transference. The analyst's ability to comprehend and interpret these feeling states and corresponding selfobject functions as they enter the transference will be critical in facilitating the analytic process and the patient's growth toward an analytically expanded and enriched affective life.

It follows from this formulation that when remnants of early selfobject failure have become prominent in structuring the analytic relationship, the central curative element may be found in the selfobject transference bond itself and its pivotal role in the articulation,
integration, and developmental transformation of the patient's affectivity. Thus the therapeutic importance of analyzing ruptures in the selfobject transference tie may not lie solely or even primarily in the "transmuting internalizations" that are believed to result from "optimal frustration" (Kohut, 1971). The therapeutic action of such analysis, in our view, lies principally in the mending of the broken selfobject tie which, when intact, provides a nexus of archaic relatedness in which the patient's detailed emotional growth and the corresponding structuralizations of the self can resume once again, in the medium of the analyst's attunement.

In order to exemplify our thesis concerning affects and selfobjects, we turn now to a consideration of the integration of depressive affect.

The Integration of Depressive Affect

Depressive affect states, such as sadness, grief, remorse, disappointment, and disillusionment, have many origins, meanings, and functions. Our focus in the present section is on how and under what circumstances depressive affect is tolerated and integrated throughout development. Our assumption is that all affects, in this case depressive affect, undergo development.

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in concert with the consolidation and structuralization of the self. Such affect integration has its earliest rudiments in the sensorimotor phase, in the specific selfobject responsiveness to the child's affect states that serves to facilitate full emotional growth and development.

Depressive affect is integrated into the structure of the self through consistent, reliable, empathic selfobject attunement. When such attunement is chronically absent or faulty, such affect may herald a break-up of the cohesion and stability of the self-organization. The capacity to identify and withstand depressive feelings without a corresponding loss of self, fear of self-dissolution, or tendency to somatize the affects has its origins in the early affect-relatedness between the child and primary caregiver. A process of mourning and grief following loss or separation can occur only if depressive affects can be identified, comprehended, and tolerated. The ability to integrate depressive affect is therefore related to early selfobject attunement, which, in turn, lends definition to the child's experience of himself, solidifying self-boundaries. Depressive disorders (as distinct from depressive affect states) are rooted in early selfobject failure, leading to an inability to integrate depressive feelings and a corresponding derailment of self-development.

Kohut (1971, 1977) has shown that the child's (or developmentally arrested patient's) phase-appropriate experiences of gradual disillusionment with idealized images of himself and his primary objects constitute critical milestones in the structuralization of the self. As an alternative to Kohut's concept of "optimal frustration," we are contending here that it is not solely or even primarily the "quantity" of the accompanying depressive affects that determines whether they will be experienced as traumatic and self-disintegrative or as tolerable and capable of being integrated into the evolving self-organization. We believe that what is crucial to the child's (or patient's) growing capacity to integrate his sadness and his painful disappointments in himself and others is the reliable presence of a calming, containing, empathic selfobject, irrespective of the "amount" or intensity of the affects involved. When the caregiver is able to tolerate, absorb, and contain the child's depressive affect states, which presupposes that they do not threaten the organization of her sense of self, she then functions to "hold the situation" (Winnicott, 1965) so that it can be integrated. Optimally, if such responsiveness is consistently present, the caregiver's selfobject functions gradually become internalized in the form of a capacity for self-modulation of depressive affect and an ability to assume a comforting, soothing attitude toward oneself. Consequently, such affect will not entail irretrievable losses in the self. The expectation that restitution will follow disruption becomes structuralized, providing the basis for a sense of self-continuity and confident hope for the future.

When a parent cannot tolerate the child's depressive feelings—because they do not conform to her own affect states, self-
organization requirements, or selfobject needs—then she will be unable to assist the child in the critical task of affect integration. When the child experiences such protracted derailments of affect attunement, he may, in order to safeguard the needed tie, blame his own depressive feelings for the selfobject failure, resulting in a pervasive, self-hating helplessness and hopelessness or—if he responds by defensively dissociating the “offending” affects—in lifelong states of emptiness. It is here, we believe, that one can find the origins of chronic depressive disorder. Such patients in analysis resist the emergence of their depressive feelings for fear that once again they will be met with the same faulty responsiveness experienced in early childhood.

Clinical Illustration

Steven, an unusually intelligent 26-year-old man, sought treatment for insomnia, failing graduate-school grades, and a sense of being “exhausted from covering over depression” in response to his girl friend of three years unexpectedly breaking their engagement. He was initially quite agitated, spending numerous sessions detailing the exact dates and times of the traumatic events that had necessitated his first contact with a psychotherapist. The breakup with his girl friend had followed closely on the heels of his mother’s emergency hospitalization—one of a series of such hospitalizations for a variety of physical and psychiatric conditions that she incurred throughout his development. Steven’s obsessional style and lack of connection with his emotional life were the most salient aspects of these early sessions. He desperately wanted to communicate in detail an accurate account of what he had experienced, and he showed an acute sensitivity to whether or not he was being understood. The patient explained that fears of being found “incorrect” or “inaccurate” were at the root of his anxiety, but it soon became clear that he believed that his feeling states, to

the extent that he experienced them at all, were unacceptable and would ultimately drive the therapist away from him and destroy the therapeutic relationship. The growing tie to the therapist was therefore continually in jeopardy.

He believed that the preservation of the tie depended upon his never making a “mistake,” which was later understood to mean that he must not express any feelings that were not in line with what he perceived the therapist required and, more importantly, that might disturb her or make her feel inadequate. Thus he was very compliant with the therapist’s interventions, but his responses were strikingly devoid of affect. He was terrified that any spontaneous feelings that might be disjunctive with the therapist’s state of mind would both be rejected by her and have a disorganizing impact on him. When an intense emotional reaction was evoked, he would become confused and panicky, seemingly unaware that he was experiencing an emotional reaction and thus completely unable to recognize its significance as a self-signal. Additionally, he was convinced that while on the surface the therapist would appear to accept his feelings, nonetheless she would secretly feel hatred, disgust, and loathing for him—especially, he said, because “they represent my feelings toward women.”

Steven’s fears of his own depressive affects maintained a prominent place in the treatment for a long period of time. Initially, he was somewhat aware of his dread of depressive feelings, believing that once he “got in touch” with them they would ultimately destroy him. He feared that he would fall into a dark hole never to return again, forever empty, helpless, and hopeless about his future. He believed that once he allowed himself to feel the massive disappointment, sadness, and remorse that lay beneath the surface, he would “go crazy” and end up like his chronically and sometimes psychotically depressed mother. Thus his dread of feeling and acknowledging his depressive affects was based in part on his strong identification with, and incomplete differentiation from, his mother. In addition, the mother’s own extreme vulnerability to depressive reactions rendered her unable to provide any sustained, attuned responsiveness to his depressive feelings. Any such reaction on Steven’s part was met with ridicule and negation, with the mother scolding him and saying, “You must think of other people’s feelings.” His parents were able neither to understand nor to tolerate the patient’s unhappiness, considering any such affect as a vicious attack on their self-esteem and efficacy as parents. At other times his despair and disappointment were met with what he perceived as superficial apologies that left him feeling not responded to, worthless, deflated, unacceptable, and empty.

During his many visits to his mother when she was in the hospital, Steven

often felt extremely upset and frightened about losing her and being left alone. On such occasions, she could focus only on herself and how she was feeling, communicating to him quite clearly that what he was feeling was unimportant and unacceptable and that his affect state must somehow correspond to her needs. Nor could he at such times turn to his father, who always seemed too preoccupied with his own grandiose schemes and fantasies to respond to his son’s distress. The emotional unavailability of his father compounded Steven’s depressive feelings and intensified his enmeshment with his mother. No collateral pathway for affect integration was
Steven thus came to believe that his depressive feelings were loathsome imperfections in himself. Since painful aspects of his subjective life could not be tolerated by his parents, he developed a firmly embedded conviction that painful affect must be “eliminated” and that “hurt must not be allowed.”

Steven's very early memories, while sparse and unarticulated (a phenomenon consistent with massive early dissociation of affect), focused on the lack of attunement to his depressive affect states. Whenever he would dare to show such emotions his mother would accuse him of being too self-absorbed like his father and uncaring about the feelings of others, meaning principally her own. She always responded to his depressive feelings in terms of how they related to her own vulnerabilities and needs at the moment. She subtly communicated to him her own fear that his depressive feelings would lead to a psychotic regression as they had with her. Steven felt continuously alienated from his parents and peers alike. In treatment he eventually portrayed his childhood as lacking in any true, genuine feelings except pervasive emptiness and hopeless despair, coupled with a constant struggle to “survive just one more day.”

Previous to the crisis situation that brought Steven to treatment he had been a most obedient son, especially in relation to his mother. When the mother found herself in intolerable social and professional situations she would rely on her “bright, creative, and compliant” only child to rescue her and “fix” what she had done wrong. Steven had become a very religious Catholic following his parents' divorce when he was eight, channeling all his energies—physical and emotional—into his religiosity. In this way he found an added structure of his increasingly chaotic inner world. His terrifying emotional reactions both to his parents' and his mother's hospitalizations were dissociated and repressed, solidifying his obsession, cerebral character style. A state of pure, affectless intellectuality became his self-ideal of perfection, embodied in his intense idealization of the Star Trek character Mr. Spock, whose life seemed completely free of the “imperfections of emotions.” His struggle to attain this affectless ideal became poignantly clear as the treatment began to bring forth hitherto disavowed aspects of his emotional life.

For Steven, depressive affects of all degrees of intensity had become embedded in specific, dangerous meaning-contexts and consequently had remained a source of powerful anxiety throughout his life. In reaction to his mother's last hospitalization and his being “dropped” by his girl friend, Steven was unable to maintain his defenses against affect. An understanding of the dangers involved in acknowledging and expressing his depressive feelings evolved gradually in the course of treatment, finally centering on two separate but interrelated dreaded outcomes. One was the expectation that his feelings would lead to further disorganization in his mother, completely precluding any accepting, affect-integrating responsiveness on her part. The other was his belief that, in the context of his merged relationship with her, he, too, would become psychologically disorganized, a hopelessly disintegrated self. Thus the emergence of depressive affect immediately triggered states of acute anxiety.

To summarize, Steven's inability to integrate depressive affect into his self-organization was seen to result from both profound self-object failure in relation to his states of sadness, grief, and disappointment and his deeply embedded association of depressive affect with the specter of disintegration—of both the self and the maternal object.

Steven’s transference relationship with the therapist quickly replicated with distinct clarity his tie with his mother. He was in constant fear that when he expressed any depressive feelings the therapist would see him as a fragile, disintegration-prone individual who was at the brink of psychosis. Additionally, he was frightened of any such mood in the therapist for fear that she, like his mother and himself, would “lose control” and become psychotic. As with his mother, he believed that the therapist's failures and mistakes were his own and felt her limitations as fatal flaws in himself. This incomplete self-object differentiation, in turn, made it all the more necessary for him to disavow any experiences of disappointment in the transference.

When depressive affects were evoked in the patient, along with the corresponding states of acute anxiety and panic, the therapist focused on the specific meaning-contexts and dreaded repetitions to which these feelings were linked. Through repeated analysis in the transference of the patient's resistances to depressive affect and the anticipated, extreme dangers that made them necessary, the therapist gradually became established for Steven as a self-object who could comprehend, accept, tolerate, and aid him in integrating these feelings, regardless of their “quantity” or intensity. Two immediate consequences followed from this consolidation of the selfobject

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transference. The first was that the patient began to feel and express formerly dissociated feelings of deep, suicidal despair. Despite the painfulness of these feelings, the therapist was able to interpret them as a developmental achievement in affect integration.

A second consequence, following from the first, was the crystallization of his conviction that his emerging depressive feelings
constituted a deadly threat to others—a remnant of countless early experiences in which he perceived that his sadness and disappointment were experienced by his mother as psychologically damaging. This theme was dramatically symbolized in dreams that followed immediately upon the disclosure of his suicidal feelings. In the imagery of these dreams he portrayed his emerging feeling states as uncontrollable destructive forces that, once unleashed, would engulf and annihilate everyone around him.

Not unexpectedly, Steven's belief that his depressive affects were dangerous and destructive to others began to dominate the transference, as he became frightened that his feelings would inflict psychological harm upon the therapist. As this fear was repeatedly analyzed in the transference its genetic roots in his mother's extreme vulnerabilities and consequent inability to tolerate and “hold” his depressive affects became clarified in increasingly bolder relief. This ongoing transference analysis, together with the patient's progressively solidifying new experience of the therapist's “good-enough” affect attunement and containment, made it possible for him not only to experience and express previously dissociated depressive feelings, but also to reunitewith ever-widening spheres of his affectivity in general and, in turn, gradually to experience himself as an emotionally complex, differentiated, and integrated human being. The establishment of the therapist as an affect-integrating selfobject thus permitted Steven's stalled emotional growth and the corresponding structuralizations of his self-experience to resume once again.

**Conclusion**

We have offered an expansion and refinement of the concept of selfobject functions, claiming that they pertain fundamentally to the integration of affect into the evolving organization of self-experience. This conceptualization brings into sharpened focus the critical developmental importance of reliable affect attunement from the caregiving surround in assisting the child in the tasks of differentiating, synthesizing, modulating, and cognitively articulating his emergent emotional states, affect-integrating functions which, in turn, contribute vitally to the structuralization of his sense of self. We exemplified this thesis by focusing on the necessary integrations of depressive affect throughout development and by presenting a clinical illustration of severe selfobject failure in this area. As our case example demonstrates, a focus on affect integration and its failures holds important implications for both the analytic approach to resistance and the understanding of the curative element in the selfobject transferences.

**References**


