Affects and Selfobjects

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We stated in chapter 2 that we regard the concept of selfobject function to be one of three foundational pillars of Kohut’s psychoanalytic psychology of the self. However, we perceive this concept to be vulnerable to two maladies that can afflict important theoretical ideas in the early phases of their evolution. On 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 chapter 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 into the organization of self-experience, and that the need for selfobject ties pertains most centrally to the need for attuned 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.

As we indicated in chapter 2, we conceive of the self as an organization of experience, referring specifically to the structure of a person’s experience of himself. The self, from this vantage point, is a psychological structure through which self-experience acquires cohesion and continuity, 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 (Emde, 1983; Lichtenberg, 1983; Basch, 1985; Stern, 1985; Beebe, 1986; Demos, 1987). Stern (1985) regards affectivity as a “self-invariant,” contributing, during the first months of life, to the development of “the sense of a core self” (p. 69). He argues that “interaffectivity”—the mutual sharing of affective states—is “the most pervasive and clinically germaine feature of intersubjective relatedness” (p. 138), determining for the infant “the shape of and extent of the shareable inner universe” (p. 152). Drawing on the work of Sander (1982), Demos (1987) claims that the rudiments of the infant’s sense of self crystallize around its inner experience of recurrent affect states, and she points to the critical part played by the responsiveness of the caregiving environment in fostering the development of the infant’s affect- (and self-) regulatory capacities. These studies bring into clear view the central importance of affect integration in the evolution and consolidation of self-experience, as well as the intersubjective matrix in which this developmental process takes place.

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 chapter that selfobject functions pertain fundamentally to the affective dimension of self-experience, and that the need for selfobject ties 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 mir-
roring of grandiose-exhibitionistic experiences points, from our perspective, to the critical role of attuned 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 caregivers 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 overall 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:

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-pattern-firming, 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 such responsiveness considerably beyond that which is implicit in his earlier, more delimited formulations of mirroring and idealizing selfobject ties.

Basch (1985), 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 (1984), 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 [p. 35].

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 func-

1Basch notes that, as early as 1915, Freud, too, had expressed the belief that defense was always against affect.
tions to certain other aspects of affective 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 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 (see chapter 4).

The earliest processes of self-demarcation and individualization thus require the presence of a caregiver 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) and thus to subjugate or dissociate central affective qualities of his own that conflict with this requirement (see Atwood and Stolorow, 1984, chapter 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 caregiver 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, chapter 3, for a clinical illustration).

AFFECT TOLERANCE AND THE USE OF AFFECTS AS SELF-SIGNALS

Closely related to the role of early selfobject experiences 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 caregiver 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.

Through countless experiences throughout early development, the caregiver, by comprehending, interpreting, accepting, and responding empathically to the child’s unique and constantly shifting 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 self-object function by way of using her own affect-signaling 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-signaling 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 comes to be experienced as a solitary and unacceptable state, a sign of a loathsome defect within the self 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 affect 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 DESOMATICIZATION 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 emphasized 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 somatically experienced affects thus serve a vital self-object 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 others. Such psychosomatic states thus represent an archaic, presymbolic pathway of affect expression through which the person unconsciously attempts to establish a self-object tie 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 self-object, the psychosomatic symptoms tend to recede or disappear, only to recur or intensify when the self-object 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 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. Further implications of this formulation for the analysis of conflict and resistance are discussed in the next two chapters.

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, a 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.

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 here 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 in concert with the consolidation and structuralization of the self. Such affect integration has its earliest rudiments in the sensorimotor phase, in the specific 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 attunement. When such attunement is chronically absent or faulty, such affect may herald a breakup 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 affect 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 affect 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, understanding caregiver, irrespective of the “amount” or intensity of the affects involved.² When

²We are objecting here to the concept of “optimal frustration” because of its retention of economic and quantitative metaphors that are remnants of drive theory. For example, when Kohut (1971) describes an optimal frustration of the child’s idealizing need as one in which “the child can experience disappointments with one idealized as-
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 began treatment at the age of 26 with a vague and generalized sense of doom and a pervasive fear that there was something terribly wrong with him. His fears centered specifically on his dread of becoming depressed, which he associated with "loss of control" over his mind and body. He complained of insomnia, failing graduate school grades, an inability to concentrate, and constant exhaustion from "covering over depression." Two events had precipitated his first visit to a psychotherapist: the broken engagement to his girlfriend of three years and the unexpected hospitalization of his mother. These two powerfully upsetting events took place on the same day three weeks before treatment had begun.

From the first session, Steven was extremely sensitive to the therapist's verbal and nonverbal reactions to him. He was usually very serious and occasionally quite anxious and agitated during the sessions. He had extreme difficulty focusing on what he wanted to communicate and his conversation often took on a distinctly dry and unconnected flavor, revealing no apparent depth of feeling. He spoke incessantly about the "traumas" he had suffered—not only recently but throughout his life—yet he was unable to provide any details of the events or recall how they made him feel. All he knew was that his life was "not quite right." Any attempt to look more deeply into this problem would create an acute sense of anxiety, panic, and confusion, occasionally accompanied by dizziness, which then made him believe that he must have a "defective core" (that is, be psychotic).

He was intensely frightened that he would ultimately become massively depressed, since he believed his "defenses were failing" him. He knew he was depressed, but he "couldn't feel it." He remembered that once before he had "given in" to his feelings and had become so depressed that he had believed that he would never recover. Steven associated this belief with a "downward spiral" into a dark, deep hole, a process that, once begun, could never be reversed. In general, this is how Steven conceived of his depressive states. Consequently, he could neither express nor fully experience them until long into the treatment.

Steven had been employed as a computer programmer after dropping out of graduate school. He held many other odd jobs, filling his days and evenings with perpetual work. His obsessional style and lack of connection with his emotional life were the most salient features of the early months of therapy. He desperately wanted to communicate an exact account of what he had experienced and he showed an acute sensitivity to whether or not he was being understood. He 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 be rejected by her and have a disorganizing impact on him. When an intense emotional reaction was evoked, he would become confused and panicky, seeming to be unaware that he was experiencing an emotional reaction and thus completely unable to recognize its significance as a signal to himself. After Steven had become able to express some feelings in the therapeutic situation, he nevertheless remained continually baffled by what he “should do with them” now that he felt them. “I don’t know what I feel, if I feel at all... if this is what a feeling is!”

Additionally, Steven was convinced that while on the surface the therapist might 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 had never experienced a deep inner sense of trust in another person and consequently was unable to believe that the therapist was not using him to fulfill her own needs, as his mother had continually done throughout his development. This lack of trust was pervasive early in the treatment and increased his vulnerability to almost intolerable proportions.

Steven’s early life was punctuated by pervasive feelings of loneliness and emotional isolation. He had few friends as a young boy, “preferring” instead to spend countless hours with his mother in what appeared to be an intensely enmeshed relationship. Throughout his life he fantasized that his only purpose in life was to take care of his mother and try to extricate her from her recurrent, prolonged states of depression. She emerged in his memories as a cynical, pessimistic, suspicious, and severely hypochondriacal woman. Most of his memories of his early experiences were vague and fragmented but, as treatment progressed, he recalled a number of times when his mother was hospitalized for a variety of physical and psychiatric conditions, which left him in continual despair. Her first prolonged hospitalization took place when Steven was two, and she was hospitalized almost yearly throughout his childhood. Steven had both disavowed his affective reactions to these hospitalizations and repressed his knowledge of the reasons for them. In light of what was learned in the treatment about the mother’s psychological state, it seems probable that many of these hospitalizations were for psychotic depressions. Steven recalled that his mother had been depressed as far back as he could remember, yet he had no conscious awareness of her psychological unavailability, nor did he recognize its impact on him.

Steven’s disavowed childhood feelings of loss and abandonment were powerfully replicated when his girlfriend unexpectedly broke off their engagement. The depressive feelings that were evoked had a disorganizing impact on him and were, he felt, completely ignored by those around him. His mother was in the hospital attending to her own needs and his father remained as unavailable and stoney as Steven had always remembered him. In treatment he could not understand why he was unable to “get over” her and thus attacked himself mercilessly for this “defect” in himself. A few months into the therapy Steven recalled that he had been getting “deeper and deeper into depression” following the breakup. “I felt as though it was spiraling downward. I began to get depressed and it continued on where I didn’t want to do anything. I had no interest. I had an intense desire not to feel and not to think. It’s a slightly suicidal tendency that scares me.”

Steven clearly had no capacity to integrate his depressive feelings following this traumatic experience of loss, nor was he capable of accepting these affects in himself. He believed that they surely must mean that he was “crazy,” for no one else understood them. Throughout his life, experiences of disappointment and sadness went unrecognized as far back as he could remember. He firmly believed that his mother could not tolerate his sadness and he remembered that she often ridiculed and berated him for feeling at all. When close childhood friends moved out of Steven’s neighborhood—a trauma Steven repeatedly suffered—both his parents would laugh at his distress, commenting on what a “joke” it was that he was so upset. Not surprisingly, in light of such early experiences, Steven was extremely sensitive to
any laughter or light-heartedness on the part of the therapist; he believed that she was ridiculing him for his feeling states as his parents had.

Steven's parents, particularly his father, had major difficulties maintaining stable relationships with others. Steven pictured his father as a reckless, self-involved man, unpredictable in both his personal and professional life, and "completely unconcerned about other people's feelings." His father abused his mother and often became absorbed in grandiose and immoral financial schemes. This left Steven with strong, conflictual feelings about him. He felt a strong desire not to believe that his father was the unethical and uncaring man he was portrayed to be and, at the same time, was filled with anger, disgust, and extreme disappointment in him. His father was incapable of recognizing how disorganizing these experiences were for his son and instead became annoyed and angry that the boy doubted his moral character.

Steven had lacked the kind of relationship he had needed with a father whom he could genuinely admire. His father's use of him to mirror his own grandiosity was prominent in Steven's recollections of their increasingly limited interactions. "He would sit me down to have father-son talks and he would go on and on. But there was one crucial thing missing. He was talking for himself, to himself, not to me. I was more of an object than another person." Steven's experience of his father as "distant," "erratic," and "unreachable" led eventually to his conviction at the age of 12 that there was no longer any hope for their relationship.

Even though Steven had little conscious awareness of his reactions to his mother's severe and repetitive depressions, his low self-esteem and propensity to become disorganized by affect states of all degrees of intensity can be assumed to be products of prolonged enmeshment with a mother who was chronically depressed and unresponsive, compounded by the lack of a stable bond with his father. Steven's own disavowed depressive affect states can be seen as a natural response to being chronically unresponded to. He shamefully admitted that he had been "depressed his whole life" but was "never able to feel it." He experienced "no zest for life, no glory in life," only a deep sense of isolation.

Steven's fears of his own depressive affects held 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, a fear that left him forever empty, helpless, and hopeless about his future. He believed that once he allowed himself to feel the massive disappointment, sadness, and remorse that had always lain beneath the surface, he would "go crazy" and end up like his psychotic 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, negation, angry scolding, or superficial apologies that left him feeling not responded to, worthless, deflated, unacceptable, and empty. His parents were unable either to understand or to tolerate his unhappiness; they considered any such affect as a vicious attack on their self-esteem and efficacy as parents.

During his many visits to his mother's hospital bedside throughout his childhood, 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 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 exacerbated Steven's depressive feelings and intensified his enmeshment with his mother. No collateral pathway for affect integration was available. 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."

Whenever Steven dared to show his 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. Her responses to his depressive feelings were always in terms of how they related to her own vulnerabilities and needs at the moment. She subtly communi-
cated 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. 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." He commented often that "each man makes his own purgatory that he must live in," implying that he was fully to blame for his despair.

Steven's early memories were sparse and unarticulated, a phenomenon consistent with his massive early dissociation of affect, a product of the relentless lack of attunement to his depressive feeling states. He referred often to what he called the "missing link" in his history and in himself, imagery that was later understood to concretize the emotional disconnectedness he had experienced throughout his development. He spoke of life events as if they had happened to someone else and found it difficult to imagine that he was the same person now that he had been earlier in his childhood. Thus Steven lacked an experience of himself as being continuous in time, because he lacked the organizing and stabilizing influence of integrated affects that solidify the experience of being the same person though in the midst of change. In the therapy, Steven would occasionally feel a loss of a "time frame," especially during separations from the therapist or at the end of a session. Forty-five minutes would seem like ten, and four-day separations like months.

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 would find herself in intolerable social and professional situations she would rely on her "bright, creative, and compliant" 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 into his religiosity. In this way he found an added source of structure for his increasingly chaotic inner world. His terrifying emotional reactions to countless disturbing childhood experiences (especially his parents' divorce and his mother's hospitalizations) were dissociated and repressed, solidifying his obsessional, 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 seems 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 being "dropped" by his girlfriend, he 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 related 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 acute anxiety.

To summarize, Steven's inability to integrate depressive affect into his self-organization was seen to result both from profound selfobject failure in relation to his states of sadness, grief, and disappointment and from 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 the therapist would see him as a fragile, disintegration-prone person who was at the brink of psychosis when he expressed any depressive feelings. He was afraid to tell the therapist his dreams, being convinced that she then would clearly see the "crazy," disorganized qualities of his thoughts and feelings. Additionally, he was frightened of any depressive moods in the therapist for fear that she, like his mother and himself, would "lose control" and become psychotic. When Steven perceived a change of mood in the therapist, he would begin to feel anxious, as if it were he experiencing it. He believed that the therapist's failures and mistakes, like his mother's, were his own, and he felt her limitations as fatal flaws in himself. This incomplete self-object differentiation, in turn, made it all the more necessary to disavow any feelings of disappointment in the transference.

When depressive affects were evoked in Steven along with the corresponding states of acute anxiety, the therapist focused on the specific meaning-contexts and dreaded repetitions of early selfobject failure to
which these feelings were linked. Whenever possible, she clarified his fears that she, like his mother, would find his feelings intolerable and unacceptable and would thus respond to them with spreading panic or angry belittlement, or become emotionally disturbed herself. Through this repeated analysis in the transference of Steven’s resistances to depressive affect and the anticipated, extreme dangers that made them necessary, the therapist gradually became established for him as a person who would comprehend, accept, tolerate, and aid him in integrating these feelings, regardless of their intensity. Four closely interrelated consequences followed from this consolidation of the selfobject dimension of the transference. The first was that Steven began to show a much greater ability to recover painful memories of his past. The second was that he began to feel and express formerly dissociated feelings of deep, suicidal despair. Despite the painfulness of these feelings, the therapist and patient were able to understand that they reflected a developmental step in affect integration.

A third consequence, following from the second, 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 bold relief. This ongoing transference analysis, together with Steven’s progressively solidifying new experience of the therapist’s affect attunement and containment, made it possible for him not only to experience and express previously dissociated depressive feelings, but to begin to reunite with ever-widening spheres of his affectivity in general and, in turn, to move toward an experience of himself as an emotionally complex human being.

The fourth consequence of the consolidation of the selfobject transference tie and the corresponding expansion of Steven’s affective life was that he showed increasing capacity to immerse himself in intensely pleasurable experiences, most notably those that emerged at this time in his first sexual relationship with a woman. Analysis of his fears of experiencing and disclosing these pleasurable feelings provided insights into the impact on Steven of his mother’s inclusion of him in her own paranoid view of the world. He remembered that his mother had told him repeatedly that she had brought him up with the overriding aim of providing him with “tools for survival”—that the world was a “very dangerous place” and that he must devote his life to the protection of himself. She conveyed her belief that feelings must not be expressed—or even felt—because they indicated to her a loss of self-control, which interrupted his concentration on self-protection, thereby rendering him vulnerable to annihilation. His positive affect states were subject to the same maternal restrictions as were his negative ones. Steven recalled only a “few moments” when his mother allowed him to feel joy and unburdened pleasure in what he happened to be immersed in as a young boy. During these times, when he began to feel the normal expansiveness of fearless pleasure in mastery, his mother would soon become alarmed and warn him that he must not give up “preparation for tomorrow’s dangers for happiness today.” This theme was clearly replicated in the transference in Steven’s expectation of the therapist’s “severe disapproval” as he began to express his newfound feelings of excitement, happiness, and carefree self-involvement. He would refer to these states as “reckless abandon” for which he expected punishment—for example, when he disclosed to the therapist the enormous satisfaction and pride he experienced in his first sexual encounter. Working through these fears of retribution in the transference, and clarifying their origins in his mother’s ever-vigilant alertness to danger, strengthened the selfobject tie to the therapist, further expanding Steven’s capacity to experience strong feeling.

A vivid example of Steven’s progress in affect tolerance arose in the context of his decision to relocate to a distant city in order to resume his education at the only graduate school at which he was accepted. He was immediately able to experience and express acute feelings of sadness and distress over the impending loss of the therapist—feelings that earlier would have had to be disavowed because of their links with early traumatic selfobject failure in this area. The understanding and
acceptance of these painful depressive affect states led to two final important therapeutic transformations, the first consisting of a newly formed dimension to the transference. Steven began to feel the loss of a "true friendship," a kind of bond he had never before felt was possible given the lack of genuineness of past relationships in his life, beginning with those he had with his parents. Such increased feelings of closeness and trust came as a direct result of Steven's growing awareness that his affect states, regardless of whether they were positive or negative, could now be understood, tolerated, and rendered intelligible by the therapist. It is notable that this new feeling of friendship crystallized shortly after intense depressive feelings had been fully expressed to the therapist. The bond had been further solidified by the affect-integrating responsiveness of the therapist, increasing Steven's sense of being worthy of her friendship.

The second consequence of the integration of Steven's feelings of loss was an unexpected illumination of his heretofore unarticulated perception of his father's emotional states. He remembered for the first time that not only was his mother chronically depressed throughout his early years, but his father too had suffered from prolonged depressions that were punctuated by extreme agitation. "I grew up believing that depression was a way of life, that there was nothing else." Steven had long attempted to avoid identification with either parent for fear of becoming like them. Since neither parent was available to provide any consistent responsiveness to his affect states, he had remained arrested in his affective development and had become increasingly enmeshed in a futile attempt to alleviate his mother's pain and suffering. In the transference, the therapist had eventually become established as the affect-integrating selfobject that Steven had sorely missed throughout his formative years. During the course of therapy, he seemed gradually to internalize the therapist's integrative attunement to his emergent feeling states and increasingly to identify with her accepting, understanding attitude toward his previously disavowed affective life. Steven's stalled emotional growth was thereby permitted to resume once again.

**CONCLUSION**

Selfobject functions 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 action of selfobject transferences. Our focus on "intersubjectivity" and its derailments also brings into clear view the specific intersubjective contexts that facilitate or obstruct the process of self development.