The Reverse Selfobject Experience

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A reverse selfobject experience occurs when an infant functions as a selfobject for the mother. While reverse selfobject experiences are a part of healthy development, excessive experiences (a) traumatize the infant, (b) contribute to a pathological grandiose self, and (c) lead to severe treatment resistance in the early stages of psychotherapy.

Since the publication of "The Analysis of Self" (1), Heinz Kohut's concept of the selfobject has gained considerable acceptance as a tool for understanding fragmentation symptoms, unearthing arrested needs, and monitoring patient/therapist interaction. The reverse selfobject experience involves an unexpected reversal in the archaic selfobject role where the infant maintains needed parental ties by serving as an archaic selfobject to them. This article explores the effects of being an archaic reverse selfobject on the development of a cohesive self and on psychotherapy. After definitions, the reverse selfobject experience is discussed under the headings of trauma, grandiosity, and resistance.

Definition.

Kohut (2) defines a selfobject as "that dimension of our experience of another person that relates to this person's shoring up of our self." (p.49). As Tolpin (3) indicates, a mother soothing an infant is an example of a person functioning as a selfobject. Kohut focused clinically on patients whose only way of experiencing other people was as selfobjects because of absent selfobject experiences in childhood. He (4) compared these understimulated patients with neurotic patients who were overstimulated by parental emotional closeness. Additionally, Kohut mentions pseudoclose patients who are "unable to respond to their childrens' changing narcissistic requirements" --- "because they are using their children for their own narcissistic needs" (p.274). Without using the term "reverse selfobject experience," Kohut says these patients functioned more as the selfobject for the mother than the mother was experienced as a selfobject for them. The reverse selfobject experience involves being a selfobject of others when at the same time there is an urgent and appropriate need to have one's own selfobject needs met. Special vulnerability to the reverse selfobject experience occurs in early infancy.

Recent writings by self psychologists support the idea of the reverse selfobject experience. Miller, (5) for example, says a child may serve as an archaic selfobject to parents in order to maintain needed ties to them. Autobiographically, she comments that she complied with the needs and feelings of her mother and ignored (her) own. Additionally, Atwood and Stolorow (6) refer to the disturbances of a child's self when needing to serve the archaic selfobject needs of a parent. And in a recent book, Stolorow, Brandchaft and Atwood (7) use the idea (although not the term) of a reverse selfobject experience to explain the clinical phenomenon of a harsh or sadistic superego which becomes an enduring source of guilt and punishment.

Trauma

Clinical work with adult patients suggests that absent or reverse selfobject experiences can traumatize an infant and impede the development of a firm sense of self. This belief is supported by Balint's (8) position that a child's trauma is contingent on the responsiveness, or lack of it, from a key parent, rather than the severity of a wound. Put another way, it is not so much the blow, nor the wounded person's reaction to the blow, but the response of a key "other" to the wounded person's reaction, which determines the extent of traumatization. So, an infant without an adequate selfobject is more likely traumatized by natural threats and wounds, than one with a soothing/comforting parent.

Although there is general consensus that an absent selfobject traumatizes an infant, parental absence in early infancy does not always produce as much adult pathology as would be expected. Kohut (9) mentions this about Mr. E, an "incubator baby" separated from his mother for several months, who was rarely picked up because he was considered fragile. In another example (10), six concentration camp orphans received surrogate mothers a few weeks after birth, and as the gas chambers took their toll, were passed from surrogate to surrogate until over three years of age. After the war, they entered a special home at Bulldog Bank, England.

At first, these children distrusted their adult caregivers, but were noticeably bonded to each other. For example, when John kicked and screamed and refused to get up one morning, Ruth, another child, brought his clothes, while Miriam offered him her doll with a sweet smile. After these siblings functioned as selfobjects, John calmed down. This suggests that when a mother is absent, infants use others as selfobjects. Bettleheim (11) reports a similar peer group bonding (hence selfobject experience) among children of Israeli kibutzim. That is, because of an innate capacity, infants seek to repair their environment.

This reparative ability offers an explanation for the reverse selfobject experience. The infant functions as a selfobject, soothing parental rage or playfully stimulating parental despair, when the infant's mother is preoccupied. The purpose of such reparative behavior is to enable the parent to selfobject the child. Because there is no perfect parent, all infants inevitably function sometimes as a reparative reverse selfobject, which strengthens their sense of agency and responsibility. Where the reverse selfobject experience is inappropriately excessive, it develops an inflated quality of responsibility at the expense of the infant's developing self.

Support for the idea that the reverse selfobject experience involves reparative behavior comes from the work of John Bowlby (12). In his four stages of mourning, yearning/searching follows an immediate response of numbness. It also comes from the restless urge to "do something" noted in the Lindemann (13) study of a tragic Boston restaurant fire. This yearning/searching behavior is seen as an attempt at repairing loss.

The idea of reparative behavior was stressed by Melanie Klein (14). She first mentions reparation in discussing the story of Ruth Kjar, a painter who, without any knowledge or experience of painting, suddenly ordered painting supplies, and after a day of feverish activity, painted a life-sized figure of a naked black woman on an empty wall space. Prior to this act, a depressed Ruth had reported "an empty space in me, which I can never fill." Klein sees this painting as concrete symbolization of a desire to repair the injured mother.

Vignette 1. An author's case illustrates the reparative effort that lies behind being a reverse selfobject. Mrs. G, an administrative assistant in a large business, became a full-time art student after entering psychotherapy. She was pursuing a goal of twenty years. After several courses, she discovered a passion for life drawing, drawing faces feverishly to bring them "to life." She sought

ways of depicting a range of feelings such as happiness or sadness, and particularly a sense of vitality. Eventually, Mrs. G realized she was expressing a deepseated childhood wish to heal the schizoid personality of her mother. She also understood her childhood behavior of acting as the cheerful, energetic daughter was an attempt to lift her mother's depression. Behind this behavior was a little girl crying out, "What about me?" The price of being a reparative reverse selfobject was the arrested development of her core self.

Clinical work with the more severely disturbed character disorders and borderline patients leaves the impression that the most traumatic effects of the reverse selfobject experience come from functions that are excessively imposed early in an infant's life. In one such function, the infant is seen by the parent as the source of all blame, keeping the parent's blamelessness and perfection intact. In this protector role the infant can be verbally, if not physically abused by the sadistic parent as if the source of all evil, and even made to feel undeserving of life itself. All infants and children experience this reverse selfobject function at some time or other, but those who experience it excessively display symptoms associated with an inadequately developed or easily fragmented self.

Vignette 2. Mrs. O, a case of the author's, functioned from early childhood, as a reverse selfobject. An unwanted ninth child when her mother was 44 years of age, she was raised by a sister while the mother went to work. Mrs. O eventually explained her mother's rejection through a delusion that she was her sister's illegitimate child. This delusion helped Mrs. O tolerate the mother's physical abuse which raised welts on Mrs. O's legs and buttocks. No real mother could act like this, she reasoned. Encouraged by the mother's sadistic behavior, the siblings bullied Mrs. O into functioning as the family scapegoat.

In her rigid, punitive family system, Mrs. O learned to conform if she wished to preserve some internal sense of self. Inwardly, she seethed with rage and fantasies of revenge. As a girl of five she had shouted at her mother, "When I get older, I will hurt you back." After puberty, she gained revenge on her mother by seducing her father into fondling her breasts. This revenge also focused on the Roman Catholic Church after a priest pressured her into confessing masturbatory behavior.

The reverse selfobject experience encourages a child to believe that the imposed selfobject function is essential for the parent's existence and that he can destroy the parent by refusing to co-operate. It also suggests that the power experienced through being a reverse selfobject is negative and destructive.

Family therapist Haley (15) believes that an early, excessive reverse selfobject experience is very costly for schizophrenics. He thinks the schizophrenic child primarily functions to hold the nuclear family together. In offering himself/herself as a tragic problem, the schizophrenic child serves as a scapegoat for the inadequacies of other family members. Haley supports this idea by pointing to clinical cases where the schizophrenic child becomes normal and leaves the family, but the parents collapse, lose their purpose in life, and get divorced.

In summary then, reverse selfobject experiences create trauma in an infant depending on the following factors: (a) prematureness, (b) excessiveness, (c) degree of imposition, and (d) type.

Grandiosity

Stolorow and Lachmann (16) define grandiosity as "the idealization of the self" (p64). Kohut believes it is a normal phase in the growth of a healthy adult. Pathological grandiosity comes from

the trauma of absent, phase-appropriate mirroring, or the excessive need to function as a reverse self object. It is manifest as "a sense of self-importance with an exhibitionistic need for attention and admiration, feelings of entitlement, lack of empathy for others, and interpersonal exploitativeness" (p.7) (17).

Clinically, an arrested grandiose self presents in many ways. As Kohut indicates, a person may inappropriately seek to control the behavior of others as if they are a part of the first person's body. In a personal relationship, sadistic behavior is the excessive attempt of the grandiose self of one person to force another person under its direct control. Socially, the ruthless seeking of power and revelling in it, expresses the needs of the grandiose self. The grandiose self makes plans that are impossible to implement, and doomed to failure from the beginning. Grandiosity may manifest itself as an exaggerated sense of responsibility, as a burden of overwhelming guilt, or as hypercritical verbal behavior which "puts down" another person. These signs of the grandiose self indicate that such a person has an overdeveloped sense of agency.

A self's sense of agency has been an important theme in philosophy and is very important also in self psychology (18). Psychoanalytic theorists Stolorow, Brandchaft and Atwood (19) make a distinction between the self as organization and the self as agent. The self as agent has gained considerable attention from researchers of early child development (20). Stearn sees the sense of agency as an essential component, citing behavioral evidence from the two to eight month period of infancy. He says that a sense of agency develops out of three "invariants of experience." These are "(1) the sense of volition that precedes a motor act, (2) the proprioceptive feedback that does or does not occur during the act, and (3) the predictability of consequences that follow the act."

The work of Stearn and others suggests that grandiosity naturally arises out of the illusory quality of the self's sense of agency. The grandiose self is more vulnerable to fragmentation if it is reinforced by an excessive reverse selfobject experience, especially when in the imposed blame role for parental woes.

Vignette 3. Mrs. X, a married, obese woman, entered treatment with the author because of "depression and a miserable marriage." The organizing principle (21) which emerged during treatment was an extremely unselfish giving of herself until personal neglect and exhaustive collapses threatened her health. She excessively functioned as a selfobject in all her relationships. Nothing was too much for her children; she volunteered to organize time-consuming projects where she taught; she immediately dropped everything to help sick friends. Not surprisingly, her own household was a disorganized mess, her marriage almost non-existent. Her husband, disinterested in sex, lacked a capacity for emotional intimacy or the inclination to selfobject anyone. She experienced him as another child who needed her care.

Mrs. X had a strained relationship with her working mother, a strong-willed, well-educated, power-oriented woman who ruthlessly clawed her way up the bureacratic ladder of a large corporation. The mother's work absented her from the home, leaving the younger siblings to Mrs. X's care. Despite efforts to please her controlling mother, Mrs. X found the mother hypercritical and seemingly never satisfied. When anything went wrong, Mrs. X was blamed. For example, when Mrs. X was ill as a girl, the mother diagnosed the problem as "measles" and put her to bed. When Mrs. X's illness worsened, the mother called the doctor who, when he came to the house, diagnosed "mononucleosis" and wanted Mrs. X hospitalized. The mother disagreed and engaged the doctor in a battle of wills during which he reminded her that she did not have a doctorate in medicine. After the doctor left, the mother blamed Mrs. X for getting her into trouble.

In summary, the experience of being a selfobject for parents and siblings fosters a sense of responsibility, agency, and a phase-appropriate grandiose self. Excessive reverse selfobject experiences, especially early in infancy, help form a pathological grandiose self with haughty, harsh or cold behavior meant to isolate or insulate such a grandiose self from wounding.

Resistance

Excessive reverse selfobject experiences in early childhood tend to produce persons resistant to psychotherapy, especially in the early stage of treatment. Clinical work with such distrustful, resisting patients ultimately reveals a hunger for a selfobject, but at the same time, a fear that prevents them from responding positively to it. They disavow their positive responsiveness to being empathically understood out of fear that their selfobject experience will turn into a reverse selfobject function and repeat their experience as infants, entrapping and retraumatizing them (22). They fear a "bait and switch" situation where selfobject needs ensnare them into a reverse selfobject role with the therapist. So they resist efforts to establish a stable working alliance (23) with behavior such as missing sessions and being late. This kind of behavior tests for whom the therapy is a selfobject.

Vignette 4. Miss M was a patient who sought psychotherapy because of unemployment difficulties and an inability to experience feelings. As an only child, she functioned as a reverse selfobject to a dominant mother who over-dressed her like a doll, who scolded her for the slightest soiling, and who rigidly expected conforming behavior. In the initial sessions Miss M awaited the therapist's directions. When encouraged to talk about matters of concern she maintained a silence or produced superficial material about work. She feared the relationship primarily designed to

serve her. Sometimes a painful situation at work evoked a few minutes of animated connectedness, but then she lapsed into silences or into a superficial, quasi-mechanical, intellectual discussion of a topic.

After three months of these sessions a new problem emerged. The patient asked "how are you?" The therapist deflected this back with "more importantly, how are you?" The patient, however, lapsed into silence, became depressed, and any attempt to explore the meaning of the silence was greeted with further silence. One day, a slight "cold" by the therapist led to a concerned involvement by Miss M. After thanking her for the concern, the therapist assured he had taken two Asprin, had a light schedule, and would, on arriving home, immediately take to bed. Miss M, visibly pleased by the therapist's assurances, was emotionally engaged for the rest of the session. Based on this experience, the therapist discovered that if he responded to her question of "how are you" with a brief response, he was rewarded by meaningful, affect-laden material. Through this material, the therapist saw that Miss M's childhood experiences left her believing she could never have her own needs met until those of others had been. After this pattern was explained and traced back to her reverse selfobject function with her mother, she began to commence sessions with engaging personal material, without first checking on the needs of the therapist. This shift heralded the beginning of a mirroring selfobject transference in the psychotherapy.

The idea of the reverse selfobject experience gives new meaning to issues arising from the therapeutic situation (24). It is generally acknowledged that matters such as missed sessions, unpaid fees, lateness, and vacations effect treatment. Stone advocates that arrangements be tempered by humane considerations. Winnicott (25) used a flexible frame to establish a facilitating environment, and gained good results with his patients. And Wolf (26) advocates an ambience that fosters optimal empathy.

Once issues of the therapeutic setting are linked with patient fears of re-experiencing a traumatic reverse selfobject function, they take on new meaning. Changes in the setting, when perceived by the client as solely for the therapist's benefit, can evoke severe patient traumatization and foster considerable therapeutic resistance. On the other hand, changes in arrangements, if perceived by the patient as empathic, are used by the patient to make therapeutic gains.

Vignette 5. Mr. C presented himself to the author for psychotherapy as a disorganized patient, obsessing about his many problems and always late for everything. His five to fifteen minute lateness every session for the first few months was eventually interpreted to him as a potentially important attempt at communication. The patient's obsessing gradually declined after the therapist interpreted his lateness as affirming the therapist's servant role by forcing him to wait. The session following, Mr. C came on time. After this session, lateness still occurred, but more intermittantly. By regularly focusing on the meaning of the patient's lateness the therapist helped the patient reduce his acting in. But once the lateness issue was resolved, Mr. C resorted to opening up the shades of the therapist's office each time he entered the room. Encouraged to verbalize his thoughts about this behavior, Mr. C eventually realized that he still needed a way to express a sense of control (agency). This was eventually understood as trying to prevent a retraumatizing reverse selfobject experience.

In summary, resistance can be induced not only by faulty therapeutic technique arising out of empathic failure, but also from the fear of a repeat of the reverse selfobject experience.

Summary

A reverse selfobject experience occurs when an infant acts in an auxiliary function for the mother. It is a part of normal development; arises from a need to repair; helps foster responsibility and a healthy sense of guilt; strengthens a growing sense of agency; and hence, is useful in developing a cohesive sense of self. Excessive, early reverse selfobject functioning is another matter. The infant is traumatized by such reverse selfobject experiences, especially when they are forced by the parent on the infant. Excessive reverse selfobject experience arrests development at the stage of the grandiose self and leads to treatment resistance from fear of repeat traumatization.

Dr. Richard Chessick is thanked for his constructive criticisms.

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Published in the American Journal of Psychotherapy, Vol. XLII, No 3, July 1988, pp. 416-424.

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American J. Psychotherapy, 42: 416-424 July 1988.

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