

On the Object Relational Texture of Affects

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Marty Mayman will be remembered as a uniquely gifted clinician, diagnostician, supervisor, and teacher. In this article, I link his distinctive capacity for empathic understanding is linked to his reliance on self- and object- representational concepts as a vehicle for accessing the inner life of his participant. Mayman's special brand of empathy was remarkable for its sensitivity to nuance as well as its ability to strike a chord with vivid resonance. His understanding of ego development included the notion that self and object representation make up part of the internalized structure of all ego functions. Self and object representations can be thought of as embedded in the individual's subjective experience of the very performing of those ego functions. Self and object representations can also be thought of as embedded in the individual's attitudes toward the exercising of particular ego functions, for example, where the individual struggles with whether or not he or she feels a sense of permission to "own" or exercise specific ego capacities. In this article I apply the use of self and object representation as a way of "texturizing" the ego to the way object relations are embedded within affects. I use some Early Memory material to elucidate the role of object relational themes in the specific way in which affects are experienced.

Marty Mayman was a remarkable clinician, diagnostician, teacher, and supervisor. He had a unique ability to make a test protocol absolutely come alive. He would listen to his supervisees' most demoralized descriptions of their latest therapeutic impasses and have them leave supervision with not only a new set of ideas about how to proceed, but with a new sense of conviction about their own ability to learn from their patients. He practiced a very special kind of empathy that consisted of an unusually nuanced feel for another person's subjective life. His ability to "feel with" the participant was enhanced by a special capacity to gain a toe-hold on the subtle facets of the very texture of the other's experience. He managed to find a way to capture how the subject experienced the workings of his or her own mind.

I was fortunate to have had many opportunities — as a doctoral student, as a supervisee, and ultimately as a colleague, to observe Marty in action and to reflect on his specialness. I believe that Marty's unique empathic ability as diagnostician, therapist, supervisor, and teacher emerged from his own equally unique way of conceptualizing the Ego. Within Marty's Ego Psychology, ego functioning developed within an object-relational matrix. This was, I think, central to his empathic style. The individual's particular ways of thinking, of attending, of remembering became accessible to Marty in part through his ability to capture those self and object representations that made up important aspects of the individual's unique ways of experiencing. As a consummate ego psychologist Marty had a passionate interest in the diversity of human experience and in the richness and complexity of aspects of the mind such as memory and affect at a time when many of his contemporaries simply bypassed them as more or less a laundry list of bland ego functions devoid of real clinical interest. Marty's particular brand of empathy reflected his particular

appreciation of the richness of inner experience associated with the functioning of the ego, emphasizing the idea that ego functions are represented mentally as complex structures.

For Marty, the assessment of thought disorder on the Rorschach was not so much a matter of identifying examples of discreet categories of primary process thinking, but more an opportunity to learn about the unique, qualitative nature of how a given individual experienced the Rorschach task. Self- and object representations were, in Marty's view, not a specific department of the ego in which experiences of self and of other had some discrete, structural representation in the mind and which exist alongside many other ego structures. Self- and object representations were embedded within memory, within thought, within affect, within the individual's experience of having and using his or her mind.

Empathy for Marty required having a sense of how it felt to the patient to use his or her memory, how it felt to address the task on the Rorschach, or of how a patient experienced the task of managing or of expressing affects. I believe the key to his achieving this type of understanding lay in his ability to identify and articulate critically important self and object representations. Such images of self and other were central to Marty's way of working, because in his view they were associated with and embedded within the representation of any given constellation of ego functions, and thereby potentially capable of providing a great deal of influence on how those functions were to be experienced. For Marty, the ability to capture these self and object representations provided a more highly pixilated screen on which to capture the particular ways the workings of his or her mind tended to register (consciously and unconsciously) in the mind of the subject.

In attempting to demonstrate how this approach can be used to elucidate a more textured, nuanced, "Maymanesque" picture of the participant's inner life, this article will focus specifically on the area of affects and on how self and object representations can help enrich our understanding of patients' affective experience.

Marty's interest in affect goes back to his earliest work at Menningers. He was continually working on pulling together his paper on affects. He joked that he had finally worked out his Comprehensive Theory of Affects but was ashamed to say that he forgot where he put it. (What made this joke funny was the fact that it was also entirely believable.)

As part of a particular interest he had in shame, Marty worked on contrasting shame as a discrete affect, with shame as an organizing experience for the personality as a whole. In this context Marty addressed the idea of affects as complex mental structures in which self and object representations are organized into the particular way a given affect will be represented mentally. Clinically, Marty had a particular interest in capturing the patient's affect in as specific a way as possible. He was suspicious of the value of "labeling" affects for the patient, where if the "label" were too general, one ran the risk of creating the paradoxical effect of leaving the patient with the sense that he or she should feel reassured and understood after being given "a bucket with a hole in it," as he would say. He liked to talk about affects containing "a story." This typically referred to an affect's object relational themes that contained a sense of what the particular feeling meant to the patient about himself in relation to others.

It is this very idea that provides the focus for this article. The idea that affects have a story – that they contain object-relational themes that are structured into the "texture" of the affect – will be elucidated. Using the following pair of responses from the Early Memories Test, it will be suggested that the above idea is a useful one in attempting to capture as fully as possible

the patients' subjective sense of their affects.

The first response, or memory, is taken from the testing of a 32 year old man who had recently begun treatment for anxiety attacks and a neurotically inhibited work history. In his attempts to address these matters early in treatment he had raised questions about his intellectual capacities, and discussing these doubts with his therapist led eventually to a referral for testing. The following material emerged on the Early Memories Test when he was asked for one of his unhappiest memories.

I remember playing soccer in, like, 4th grade. I was the goalie for our team. I remember we were supposed to be playing on one field, and for some reason we had to switch to a different field where the goals were adult size instead of the smaller kid size that I was used to. It was unbelievable to me that nobody said anything about this being a problem of any kind. I mean, this goal was huge compared to what I was used to, and nobody else seemed to notice. We started the game, and within the first few minutes the other team shot and scored. I never got close to stopping it – and I just burst into tears. It was terrible. The coach came out and said it was okay. He said it really wasn't fair to switch to the adult size goals, but by that point I think I felt worse about having cried. It's a pretty miserable memory. (How see self?) I see myself walking out onto the field and standing in goal. (What stands out?) Just the immense size of the goal compared to my size. When I think about it now, it's also that I couldn't say anything. (Yes. What stands out about that?) It's like I was hoping somebody else would say something. I felt I just wasn't supposed to. I was afraid to, I guess. (Remember feeling when burst into tears) Like it just came out. I just felt so miserable. I couldn't help it.

Discussion of First Memory

My focus in discussing this clinical material is restricted to the issues pertaining to the patient's affective life. There are obviously other tempting points of departure in the material for various areas of analysis, not the least of which is the intriguing way in which this underachieving man who had so conscientiously kept his goals too small tells us so poignantly about a time when the goals were so painfully too big. However, in narrowing the focus to the patient's affective life (the texture of his affective experience, the meanings he ascribes to having feelings, the meaning he ascribes to expressing them), we hardly sacrifice anything in the way of poignancy, since I believe the memory conveys, in quite a compelling way, certain critically important aspects of the patient's subjective sense of his own emotional receptivity. The point I want to emphasize in particular, however, is that the access provided us by the memory to the poignancy and inner specificity of the patient's experience derives in large part from the vivid depiction of the self- and object- representations that imbue the patient's affects. Not only does the memory allow us to appreciate this man's self representation as too small, but it allows us to consider such a self-representation in even more precise ways. We

can consider this self-representation in conjunction with the question of how affective experience is represented, or how an emotionally receptive self is represented mentally.

We can easily empathize with the patient's image of himself standing alone and unprotected, in the never acknowledged too-bigness of the (adult) goal. We can easily empathize with his silent attempt to contain the intensity of his need for acknowledgment and protection. However, I think it is when we understand how these self-representations capture how small he feels in feeling his feelings that we can then empathize in a more Mayman-esque manner – one that locates us within the patient's mind in the sense that we are now in touch with tangible aspects of the patient's subjective experience.

At the point that this memory and the image of the small boy in the big goal begins to form a picture of the way feelings feel to this man, we begin to understand something terribly important about (literally) how the patient feels. This understanding comes via a self-representation embedded within an ego function. It is the mental representation of "self-as-emotionally-receptive" that I believe is captured in this particular image of the boy in the goal.

When we say (as Marty undoubtedly would have) that this memory talks about shame, we are addressing (as Marty would have) more than a general notion that shame pertains to the experience of being exposed as small, or as incontinent, or as helpless. In the memory we see how shame can hinge on very particular images of the self as incompetent in very particular ways, and on having that incompetence exposed to very particular objects. Feelings of inadequacy generally involve the idea of not being up to snuff in relation to some specific idealized image of self or object. Clinically, it is extremely useful to be able to articulate such idealized or de-idealized images of self- and object which are associated with particular tasks and functions.

It is understandable that when a task, for example, managing affective receptivity, becomes associated with particular self- and object representations such as when the self is cast as a puny, incompetent "goalie," that this affects how the individual experiences the performing of that function. When managing one's affective receptivity is associated with an image of others as "too-big," this, too, will affect one's experience of the task. Articulating such self-and object representations helps considerably in creating a more nuanced picture of the individual's experience.

Such mental representations of self and other can also be seen as informing the way affects themselves are understood by the participant, and in this way can influence the way the affects feel. Affects can be represented, for example, as "other" where the subject experiences his own affects as "other" or as "much more powerful other" or as an opponent against whom the self is seen as defenseless. When the patient quite correctly reflects on his need to remain silent in the memory and contain his anxiety when noticing the much larger goal we can observe the way anxiety is depicted as "other" and how his sense of urgency is experienced as a bodily substance to contain. Along with the representation of anxiety as object (as bodily substance) we have the related sense of the patient's self-representation as goalie/sphincter who must at all cost let nothing pass even as he senses he is too small and weak relative to the size of the challenge. In the memory, the patient's shame experience revolves not so much around giving up the goal, but more around his dread of acknowledging the sense of urgency associated with needing help from others. This image of his urgency feels like a terrible revelation of inadequacy, in part due to the ways that the task of managing urgency is associated with specific images of self and other. These specific mental images of the self, helpless in the face of urgency, then reinforce a specific sense of the weakness and inadequacy of self and a sense of the inferiority of self in relation to (idealized) others.

The second response to the Early Memories Test was obtained from a 37 year old woman who was tested soon after beginning intensive psychotherapy for a mixed picture of depression and anxiety. Included in this symptom picture was an incapacitating fear of flying which had failed to respond to a previous attempt at cognitive-behavioral treatment. The patient's highly successful work life had recently begun to make new demands for more frequent travel, and the testing was in part initiated in an attempt to obtain help with the particular problem of her phobia around air travel. This particular memory was evoked by inviting the patient to recall an early memory of a time when she remembered feeling alone. (I generally include this as a more or less standard category in my administration of EM's. This idea came out of an informal case discussion over lunch with Marty many years ago.)

I was 4, and I was in the park near where we lived, and there was a fire of some kind in the park – a brush fire, or something, and the park was surrounded by fire engines. My mother had just given birth to my younger sister and was in the hospital. My older sister took me to the park every day while my mother was in the hospital. My sister supposedly looked after me. She basically hung out with her friends. I remember her with her friend pointedly ignoring me. So I was pretty much on my own. I remember that sense of being on my own, feeling a little sad, maybe a little sorry for myself, but it wasn't a particular bad feeling. I remember hearing all those fire engines surround the park. I don't remember seeing the fire; I just remember hearing the fire engines. (See self in memory?) My image of myself is of being in the middle of the park, in the center of all this action, like I'm surrounded, but not in a bad way – it's more like I'm in the eye of the storm. The fire engines are out around the perimeter, and I'm in the center. I don't remember feeling especially scared. It's weird. I want to say I'm taking it all in, thinking that I will tell my mother all about it when I see her. (How do you mean weird?) When I think about it now, I should have been really scared – panicked even – but I just remember this sense of – just kind of taking it in. I'm not exactly calm – more just accepting what's hapening - feeling kind sad. (Sad?) A little sorry for myself? I'm not sure. Anyway, my sister found me and took me home. I probably did tell my mother about it later. Maybe just enough to get my sister in trouble. (Laughs).

This memory shares with the first memory a similarly high degree of vividness, richness, and poignancy. It is also similarly concerned with themes of containing and managing highly charged, powerful emotional reactions with which the patient appears to struggle. As with the first memory, this presents an opportunity to consider a number of questions concerning the subjective texture of the patient's affect life. How is the task of managing affect represented in the memory? What self- and object representations are associated with the management of affect? How do object- relational themes contribute to the way affects and their management are represented in the mental life of the patient? How do these mental representations contribute to the way affects actually feel to the patient?

Although the managing of affect in both memories relies heavily on themes of containing,

the particular nature of this containment differs considerably between the two memories. In our second memory, the strategy for managing affect involves “taking it all in” in contrast to the intense need to control what gets in and what gets out as seen in the first memory. The strategy of taking it all in involves using the self (and the body) to absorb and thereby contain that which might otherwise feel unmanageable. A sense of relative safety is potentially achievable, dependent not so much on the self’s goal-tending abilities, but on the ability to create of the self-as-body a danger-free zone. The patient’s image of “the eye of the storm” conveys this representation of the self, as does the sense of “circling the wagons” conveyed in the depiction of the fire engines encircling the park. Even though the fire is presumably located within this perimeter, the sense of the memory is that by creating a circle, the self is now configured in a manner that allows it to absorb the danger.

The “taking in” as depicted is also very much linked to the notion of holding in the danger until it can be delivered to the mother and deposited where it presumably belongs in the first place. This is literally a “holding action” where to hold it for the (delivering/pregnant) mother permits not only a way to tolerate the immediate danger, but also to tolerate the mother’s absence. Here, the identification with the pregnant mother as well as with the delivering mother is itself a circular holding action. The fantasy of being the same as the pregnant mother permits greater tolerance for mother’s absence by carrying her inside; and at the same time by finding a way to carry her inside, the patient can feel more like the mother.

The managing of affect is represented in ways that bear the stamp of these object relational themes. The notions of managing affect by absorbing, holding, and delivering, can be seen as significant contributors to the patient’s affective experience. Neither the experience of holding affects nor that of delivering them seems to leave much opportunity for feeling them. The developmental goal that affects in adolescence come to be treated as data for the self (Krystal, 1975) would seem difficult to reconcile with the notion that affects are held pending delivery to the mother.

The idealized images of pregnancy as a state of protective holding in which danger can be absorbed into the self and thereby rendered manageable would also seem to be an important object-relational factor affecting the patient’s experience of her emotional life. Especially where such idealized self-representations could be expected in the course of real life to be seriously challenged, the ensuing “miscarriage” of the idealized representation of self-as-affect manager could be expected to give way, when sufficiently challenged, to the complementary negative version, where the self is experienced instead as woefully lacking in internal resources, devoid of any ability to contain and protect.

It is interesting in this regard that subsequent to the testing, in discussing the test report with the patient’s therapist, it emerged that the patient’s fear of flying involved the fantasy that the plane in which she’d be flying would develop problems maintaining cabin pressure, and that the plane would implode, causing her to be sucked out of the plane into space. Here, then, is the reverse of the idealized version of the story expressed in the Early Memory, where the patient is inside the body of the plane, and in the face of her anxiety, the idealized magical fantasy of being protectively absorbed, contained, and delivered, essentially implodes. When the pressure cannot be maintained effectively within the protective body, there is then ultimately nothing within to prevent its collapse. Instead of safe and secure delivery, there is the fantasy of the terrifying, sudden loss of any sense of holding, and she is released into space.

It would seem that the patient’s experience of herself in terms of possessing (or not)

internal resources for the management of affect would be a crucial factor in her subjective experience of anxiety in particular, but also of affects in general. Similarly, the particular affective texture provided by the particular self and object representations called into play around the question of what it means to possess (or not possess) internal resources would have a distinctive and powerful impact on the organization and subjective experience of affective states.

Conclusion

Marty Mayman's unique empathic style was both a critical aspect of what he taught as well as a distinctive feature of how he taught it. As a teacher and supervisor, his empathic sense of his students' experience of their own capacity to manage the affective realm of being a therapist (and the even more difficult affective realm of learning to become a therapist) made him a remarkably inspiring teacher – all the more remarkable because he was inspiring without being remotely charismatic or possessing other of the expressive attributes normally associated with the notion of being inspirational. In his own quiet, disheveled, disorganized way, Marty inspired you by virtue of his unflagging empathic confidence in your ability to grow. You left supervision experiencing a confidence from within yourself that your own ability to manage as a therapist would continue to develop.

What made this all the more remarkable was the fact that Marty rarely inspired others to feel confident in him. Most of his supervisees, colleagues, and friends worried a lot about Marty's own ability to manage, yet he managed to inspire in them a profound hopefulness about themselves. Supervision with Marty involved the sense that one's own experience in working with the patient was always in focus for Marty, and that his investment in the patient or in his own teaching never detracted from his investment in and respect for your learning as you experienced it.

I have attempted to highlight here the particular use of self and object representation that seemed to figure so centrally in Marty's way of working. While it may not come as naturally to the rest of us as it did to him, I'm left with that familiar sense of confidence that we can and will continue to learn and grow with much thanks to Marty Mayman.

REFERENCES

Krystal, Henry. Affect Tolerance. *Annual of Psychoanalysis*, 1975, Vol. III, 179-219.