Chapter 1

Exploring the Infant’s Subjective Experience: A Central Role for the Sense of Self

ANYONE CONCERNED with human nature is drawn by curiosity to wonder about the subjective life of young infants. How do infants experience themselves and others? Is there a self to begin with, or an other, or some amalgam of both? How do they bring together separate sounds, movements, touches, sights, and feelings to form a whole person? Or is the whole grasped immediately? How do infants experience the social events of “being with” an other? How is “being with” someone remembered, or forgotten, or represented mentally? What might the experience of relatedness be like as development proceeds? In sum, what kind of interpersonal world or worlds does the infant create?

Posing these questions is something like wondering what the universe might have been like the first few hours after the big bang. The universe was created only once, way out there, while interpersonal
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worlds are created, in here, every day in each new infant's mind. Yet both events, at almost opposite frontiers, remain remote and inaccessible to our direct experience.

Since we can never crawl inside an infant's mind, it may seem pointless to imagine what an infant might experience. Yet that is at the heart of what we really want and need to know. What we imagine infant experience to be like shapes our notions of who the infant is. These notions make up our working hypotheses about infancy. As such, they serve as the models guiding our clinical concepts about psychopathology: how, why, and when it begins. They are the wellspring of ideas for experiments about infants: what do they think and feel? These working theories also determine how we, as parents, respond to our own infants, and ultimately they shape our views of human nature.

Because we cannot know the subjective world that infants inhabit, we must invent it, so as to have a starting place for hypothesis-making. This book is such an invention. It is a working hypothesis about infants' subjective experience of their own social life.

The proposed working theory arises now, because the enormous research advances of the recent past have put in our hands whole new bodies of information about infants, as well as new experimental methods to inquire about their mental life. The result is a new view of the infant as observed.

One aim of this book is to draw some inferences about the infant's subjective life from this new observational data. This has not been done before, for two reasons. On the one hand, developmentalists, who are creating this new information, generally work within the tradition of observational and experimental research. In keeping with that approach, they choose not to make inferential leaps about the nature of subjective experience. Their emphasis on objective phenomena, even in clinical matters, is in line with the phenomenological trend now prevalent in American psychiatry, but it places severe limits on what can be embraced as clinical reality—objective happenings only, not subjective happenings. And just as importantly, this approach remains unresponsive to the basic questions about the nature of the infant's experience.

Psychoanalysts, on the other hand, in building their developmental theories continually make inferences about the nature of the infant's subjective experiences. This has been both a liability and a great
strength. It has permitted their theories to embrace a larger clinical reality that includes life as subjectively experienced (and that is why it works clinically). But they have made their inferential leaps on the basis of reconstructed clinical material alone, and in the light of older and outdated views of the infant as observed. The new observational data has not yet been fully addressed by psychoanalysis, although important attempts in that direction have begun (see, for example, Brazelton 1980; Sander 1980; Call, Galenson, and Tyson 1983; Lebovici 1983; Lichtenberg 1981, 1983).

I have worked for some years as both a psychoanalyst and a developmentalist, and I feel the tension and excitement between these two points of view. The discoveries of developmental psychology are dazzling, but they seem doomed to remain clinically sterile unless one is willing to make inferential leaps about what they might mean for the subjective life of the infant. And the psychoanalytic developmental theories about the nature of infant experience, which are essential for guiding clinical practice, seem to be less and less tenable and less interesting in light of the new information about infants. It is against this background, which I know to be shared by many others, that I will attempt to draw inferences about the infant’s subjective social experience from this new data base. The aims of this book, then, are to use these inferences to describe a working hypothesis of the infant’s experience and to evaluate their possible clinical and theoretical implications.

Where can we start inventing infants’ subjective experience of their own social life? I plan to start by placing the sense of self at the very center of the inquiry.

The self and its boundaries are at the heart of philosophical speculation on human nature, and the sense of self and its counterpart, the sense of other, are universal phenomena that profoundly influence all our social experiences.

While no one can agree on exactly what the self is, as adults we still have a very real sense of self that permeates daily social experience. It arises in many forms. There is the sense of a self that is a single, distinct, integrated body; there is the agent of actions, the experiencer of feelings, the maker of intentions, the architect of plans, the transposer of experience into language, the communicator and sharer of personal knowledge. Most often these senses of self reside out of awareness, like breathing, but they can be brought to
and held in consciousness. We instinctively process our experiences in such a way that they appear to belong to some kind of unique subjective organization that we commonly call the sense of self.

Even though the nature of self may forever elude the behavioral sciences, the sense of self stands as an important subjective reality, a reliable, evident phenomenon that the sciences cannot dismiss. How we experience ourselves in relation to others provides a basic organizing perspective for all interpersonal events.

The reasons for giving the sense of self a central position, even—or especially—in a study of the preverbal infant, are many. First, several senses of the self may exist in preverbal forms, yet these have been relatively neglected. We comfortably assume that at some point later in development, after language and self-reflexive awareness are present, the subjective experience of a sense of self arises and is common to everyone, providing a cardinal perspective for viewing the interpersonal world. And certainly a sense of self is readily observable after self-reflexive awareness and language are present. A crucial question for this book is, does some kind of preverbal sense of self exist before that time? There are three possibilities. Language and self-reflection could act simply by revealing senses of the self that had already existed in the preverbal infant, that is, by making them evident as soon as the child can give an introspective account of inner experiences. Alternatively, language and self-reflection could transform or even create senses of the self that would only come into existence at the very moment they became the subject matter of self-reflection.

It is a basic assumption of this book that some senses of the self do exist long prior to self-awareness and language. These include the senses of agency, of physical cohesion, of continuity in time, of having intentions in mind, and other such experiences we will soon discuss. Self-reflection and language come to work upon these preverbal existential senses of the self and, in so doing, not only reveal their ongoing existence but transform them into new experiences. If we assume that some preverbal senses of the self start to form at birth (if not before), while others require the maturation of later-appearing capacities before they can emerge, then we are freed from the partially semantic task of choosing criteria to decide, a priori, when a sense of self really begins. The task becomes the more familiar one of describing the developmental continuities and changes
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in something that exists in some form from birth to death.

Some traditional psychoanalytic thinkers dismiss the whole issue of a preverbal subjective life as outside the pale of legitimate inquiry on both the methodological and the theoretical grounds just mentioned. They are joined in this position by many developmental experimentalists. Legitimate inquiry about human experience would, in that view, preclude the study of its very origins.

And that is exactly what we wish to study. Accordingly, it must be asked, what kind of a sense of self might exist in a preverbal infant? By “sense” I mean simple (non-self-reflexive) awareness. We are speaking at the level of direct experience, not concept. By “of self” I mean an invariant pattern of awareneses that arise only on the occasion of the infant’s actions or mental processes. An invariant pattern of awareness is a form of organization. It is the organizing subjective experience of whatever it is that will later be verbally referenced as the “self.” This organizing subjective experience is the preverbal, existential counterpart of the objectifiable, self-reflective, verbalizable self.

A second reason for placing the sense of self, as it may exist preverbally, at the center of this inquiry is the clinical one of understanding normal interpersonal development. I am mostly concerned with those senses of the self that are essential to daily social interactions, not to encounters with the inanimate world. I will therefore focus on those senses of the self that if severely impaired would disrupt normal social functioning and likely lead to madness or great social deficit. Such senses of the self include the sense of agency (without which there can be paralysis, the sense of non-ownership of self-action, the experience of loss of control to external agents); the sense of physical cohesion (without which there can be fragmentation of bodily experience, depersonalization, out-of-body experiences, derealization); the sense of continuity (without which there can be temporal disassociation, fugue states, amnesias, not “going on being,” in Winnicott’s term); the sense of affectivity (without which there can be anhedonia, dissociated states); the sense of a subjective self that can achieve intersubjectivity with another (without which there is cosmic loneliness or, at the other extreme, psychic transparency); the sense of creating organization (without which there can be psychic chaos); the sense of transmitting meaning (without which there can be exclusion from the culture, little
socialization, and no validation of personal knowledge). In short, these senses of the self make up the foundation for the subjective experience of social development, normal and abnormal.

A third reason for placing the sense of self at the center of a developmental inquiry is that recently there have been renewed attempts to think clinically in terms of various pathologies of the self (Kohut 1971, 1977). As Cooper (1980) points out, however, it is not that the self has been newly discovered. The essential problem of the self has been crucial to all clinical psychologies since Freud and for a variety of historical reasons has culminated in a psychology of the self. It has also been central to many of the dominant strains in academic psychology (for example, Baldwin 1902; Cooley 1912; Mead 1934).

The final reason to focus upon the sense of self in infancy is that it fits with a strong clinical impression about the developmental process. Development occurs in leaps and bounds; qualitative shifts may be one of its most obvious features. Parents, pediatricians, psychologists, psychiatrists, and neuroscientists all agree that new integrations arrive in quantum leaps. Observers also concur that the periods between two and three months (and to a lesser degree between five and six months), between nine and twelve months, and around fifteen to eighteen months are epochs of great change. During these periods of change, there are quantum leaps in whatever level of organization one wishes to examine, from electroencephalographic recordings to overt behavior to subjective experience (Emde, Gaensbauer, and Harmon 1976; McCall, Eichhorn, and Hogarty 1977; Kagan, Kearsley, and Zelazo 1978; Kagan 1984). Between these periods of rapid change are periods of relative quiessence, when the new integrations appear to consolidate.

At each of these major shifts, infants create a forceful impression that major changes have occurred in their subjective experience of self and other. One is suddenly dealing with an altered person. And what is different about the infant is not simply a new batch of behaviors and abilities; the infant suddenly has an additional “presence” and a different social “feel” that is more than the sum of the many newly acquired behaviors and capacities. For instance, there is no question that when, sometime between two and three months, an infant can smile responsively, gaze into the parent’s eyes, and coo, a different social feel has been created. But it is not these
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behaviors alone, or even in combination, that achieve the transformation. It is the altered sense of the infant's subjective experience lying behind these behavioral changes that makes us act differently and think about the infant differently. One could ask, which comes first, an organizational change within the infant or a new attribution on the part of the parent? Does the advent of new infant behaviors such as focal eye contact and smiling make the parent attribute a new persona to the infant whose subjective experience has not as yet changed at all? In fact, any change in the infant may come about partly by virtue of the adult interpreting the infant differently and acting accordingly. (The adult would be working within the infant's proximal zone of development, that is, in an area appropriate to infant capacities not yet present but very soon to emerge.) Most probably, it works both ways. Organizational change from within the infant and its interpretation by the parents are mutually facilitative. The net result is that the infant appears to have a new sense of who he or she is and who you are, as well as a different sense of the kinds of interactions that can now go on.

Another change in sense of self is seen at about age nine months, when suddenly infants seem to sense that they have an interior subjective life of their own and that others do too. They become relatively less interested in external acts and more interested in the mental states that go on "behind" and give rise to the acts. The sharing of subjective experience becomes possible, and the subject matter for interpersonal exchanges is altered. For example, without using any words, the infant can now communicate something like "Mommy, I want you to look over here (alter your focus of attention to match my focus of attention), so that you too will see how exciting and delightful this toy is (so that you can share my subjective experience of excitement and pleasure)." This infant is operating with a different sense of self and of other, participating in the social world with a different organizing subjective perspective about it.

Given the sense of self as the starting point for this inquiry into the infant's subjective experience of social life, we will examine the different senses of self that appear to emerge as the maturation of capacities makes possible new organizing subjective perspectives about self and other. And we will examine the implications of such a developmental process for clinical theory and practice. The following is a summary of the major points of our examination.
Infants begin to experience a sense of an emergent self from birth. They are predesigned to be aware of self-organizing processes. They never experience a period of total self/other undifferentiation. There is no confusion between self and other in the beginning or at any point during infancy. They are also predesigned to be selectively responsive to external social events and never experience an autistic-like phase.

During the period from two to six months, infants consolidate the sense of a core self as a separate, cohesive, bounded, physical unit, with a sense of their own agency, affectivity, and continuity in time. There is no symbiotic-like phase. In fact, the subjective experiences of union with another can occur only after a sense of a core self and a core other exists. Union experiences are thus viewed as the successful result of actively organizing the experience of self-being-with-another, rather than as the product of a passive failure of the ability to differentiate self from other.

The period of life from roughly nine to eighteen months is not primarily devoted to the developmental tasks of independence or autonomy or individuation—that is, of getting away and free from the primary caregiver. It is equally devoted to the seeking and creating of intersubjective union with another, which becomes possible at this age. This process involves learning that one's subjective life—the contents of one's mind and the qualities of one's feelings—can be shared with another. So while separation may proceed in some domains of self-experience, new forms of being with another are proceeding at the same time in other domains of self-experience. (Different domains of self-experience refer to experiences that occur within the perspective of different senses of the self.)

This last point highlights a more general conclusion. I question the entire notion of phases of development devoted to specific clinical issues such as orality, attachment, autonomy, independence, and trust. Clinical issues that have been viewed as the developmental tasks for specific epochs of infancy are seen here as issues for the lifespan rather than as developmental phases of life, operating at essentially the same levels at all points in development.

The quantum shifts in the social "presence" and "feel" of the infant can therefore no longer be attributed to the departure from one specific developmental task-phase and the entrance into the next.
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Instead, the major developmental changes in social experience are attributed to the infant's acquisition of new senses of the self. It is for this reason that the sense of self looms so large in this working theory. The sense of self serves as the primary subjective perspective that organizes social experience and therefore now moves to center stage as the phenomenon that dominates early social development.

Four different senses of the self will be described, each one defining a different domain of self-experience and social relatedness. They are the sense of an emergent self, which forms from birth to age two months, the sense of a core self, which forms between the ages of two and six months, the sense of a subjective self, which forms between seven to fifteen months, and a sense of a verbal self, which forms after that. These senses of self are not viewed as successive phases that replace one another. Once formed, each sense of self remains fully functioning and active throughout life. All continue to grow and coexist.

Infants are seen as having a very active memorial and fantasy life, but they are concerned with events that actually happen. (“Seductions,” as Freud first encountered them in clinical material, are real events at this stage of life. There are no wish fulfilling fantasies.) The infant is thus seen as an excellent reality-tester; reality at this stage is never distorted for defensive reasons. Further, many of the phenomena thought by psychoanalytic theory to play a crucial role in very early development, such as delusions of merger or fusion, splitting, and defensive or paranoid fantasies, are not applicable to the infancy period—that is, before the age of roughly eighteen to twenty-four months—but are conceivable only after the capacity for symbolization as evidenced by language is emerging, when infancy ends.

More generally, many of the tenets of psychoanalysis appear to describe development far better after infancy is over and childhood has begun, that is, when speech is available. This observation is not meant as a disconfirmation of psychoanalytic theory; it is a suggestion that psychoanalytic theory has been misapplied to this earlier period of life, which it does not describe well. On the other hand, academic working theories that describe the infancy period do not give adequate importance to subjective social experience. The emphasis in this account on the development of the sense of self is a step in
the direction of gradually finding theories that better fit the observable data and that will ultimately prove of practical import in dealing with subjective experience.

Finally, one of the major clinical implications of the proposed working hypothesis is that clinical reconstructions of a patient's past can best use developmental theory to help locate the origin of pathology in one of the domains of self-experience. Since the traditional clinical-developmental issues such as orality, autonomy, and trust are no longer seen as occupying age-specific sensitive periods but as being issues for the life span, we can no longer predict the actual developmental point of origin of later-emerging clinical problems involving these issues, as psychoanalysis has always promised. We can, however, begin to make predictions about the origins of pathology in the various domains of self-experience. The result is a greater freedom in therapeutic exploration.

These, then, are the general outlines of the working theory that will result from making clinically informed inferences from the newly available infancy data. Because the different senses of the self are so central to this account, separate chapters of part 2 of this book are devoted to describing how each new sense of self comes about, what maturing capacities and abilities make it possible, what new perspective it adds to the infant's social world view, and how this new perspective enhances the infant's capacity for relatedness. Part 3 then looks at some clinical implications of this working theory, from differing viewpoints. Chapter 9 looks at the "observed infant" with a clinical eye. Chapter 10 reverses that perspective and looks at the reconstructed infant of clinical practice with the eye of an observer of infants. And the last chapter looks at the implications of this developmental viewpoint for the therapeutic process of reconstructing a patient's past.

First, however, it seems essential to explain in greater detail the nature of my approach and its problems. Chapter 2 will address those issues, in particular the advantages and limitations of combining data from experimental and clinical sources; the rationale for placing the sense of self at the center of a developmental account of social experience; and the conceptualization of the developmental progression of senses of the self.
Chapter 2

Perspectives and Approaches to Infancy

THE PICTURE of infant experience suggested in this book has both differences from and similarities to the pictures currently drawn by psychoanalysis and developmental psychology. Since the approach I have adopted borrows methods and findings from developmental psychology and insights from clinical practice, it is important to discuss in greater detail the assumptions of each discipline and the problems of using both approaches together.

The Observed Infant and the Clinical Infant

Developmental psychology can inquire about the infant only as the infant is observed. To relate observed behavior to subjective experience, one must make inferential leaps. Clearly, the inferences will be more accurate if the data base from which one is leaping is extensive and well established. The study of intrapsychic experience must be informed by the findings of direct observation, as the source of most new information about infants continues to be naturalistic.
and experimental observations. But at best, the observations of an infant's available capacities can only help to define the limits of subjective experience. To render a full account of that experience, we require insights from clinical life, and a second approach is needed for this task.

In contrast to the infant as observed by developmental psychology, a different "infant" has been reconstructed by psychoanalytic theories in the course of clinical practice (primarily with adults). This infant is the joint creation of two people, the adult who grew up to become a psychiatric patient and the therapist, who has a theory about infant experience. This recreated infant is made up of memories, present reenactments in the transference, and theoretically guided interpretations. I call this creation the clinical infant, to be distinguished from the observed infant, whose behavior is examined at the very time of its occurrence.

Both of these approaches are indispensable for the present task of thinking about the development of the infant's sense of self. The clinical infant breathes subjective life into the observed infant, while the observed infant points toward the general theories upon which one can build the inferred subjective life of the clinical infant.

Such a collaboration was not conceivable before the last decade or so. Up to that point, the observed infant concerned mostly nonsocial encounters: physical landmarks like sitting and grasping or the emergence of capacities for perceiving and thinking about objects. The clinical infant, on the other hand, has always concerned the social world as subjectively experienced. So long as these two infants involved different issues, they could go their own ways. Their coexistence was nonproblematic, and their collaborative potential was small.

But this is no longer the case. Observers of infants have recently begun to inquire about how and when infants might see, hear, interact with, feel about, and understand other persons as well as themselves. These efforts are bringing the observed infant in line with the clinical infant to the extent that both concern versions of the infant's lived social experience, including the infant's sense of self. Their coexistence now invites comparisons and cooperation.

The problem raised by drawing upon these two differently derived infants is, to what extent are they really about the same thing? To what extent do they share common ground, so that they can be
joined for one purpose? At first glance, both viewpoints appear to be about the real infant's social experience. If this is so, then each should be able to validate or invalidate the claims of the other. However, many believe that the two versions are not at all about the same reality and that the conceptualizations of one are impervious to the findings of the other. In that case, there would exist no common meeting ground for comparison, and possibly not even for cooperation (Kreisler and Cramer 1981; Lebovici 1983; Lichtenberg 1983; Cramer 1984; Gautier 1984).

The dialogue between these two views of infancy and how they may influence one another is a secondary theme of this book. The way in which they together can illuminate the development of the infant's sense of self is the primary theme. For both purposes, it is important to examine each view more fully.

A clinical infancy is a very special construct. It is created to make sense of the whole early period of a patient's life story, a story that emerges in the course of its telling to someone else. This is what many therapists mean when they say that psychoanalytic methodologies is a special form of story-making, a narrative (Spence 1976; Ricoeur 1977; Schafer 1981). The story is discovered, as well as altered, by both teller and listener in the course of the telling. Historical truth is established by what gets told, not by what actually happened. This view opens the door for the possibility that any narrative about one's life (especially one's early life) may be just as valid as the next. Indeed, there are competing theories, or potential narratives, about what early life was actually like. The early life narratives as created by Freud, Erikson, Klein, Mahler, and Kohut would all be somewhat different even for the same case material. Each theorist selected different features of experience as the most central, so each would produce a different felt-life-history for the patient.

Viewed in this way, can any narrative account ever be validated by what was thought to have happened in infancy? Schafer (1981) argues that it cannot. He suggests that therapeutic narratives do not simply explicate or reflect what may actually have happened back then; they also create the real experience of living by specifying what is to be attended to and what is most salient. In other words, real-life-as-experienced becomes a product of the narrative, rather than the other way around. The past is, in one sense, a fiction. In this view, the notion of mutual validation between the clinical
(narrated) infant and the observed infant is out of the question. No meeting ground exists.\footnote{The two infants live at different levels of epistemological discourse. For Schafer, therefore, the issue of the validity of a narrative is strictly an internal matter. The issue is never a question of whether the life narrative was observably true back when, but of whether the life story "appears to the narrator after careful consideration to have the virtues of coherence, consistency, comprehensiveness, and common sense" (p. 46).}

Ricoeur (1977) takes a less extreme position. He does not believe, as does Schafer, that no meeting ground for external validation exists. If that were so, he argues, it would "turn psychoanalytic statements into the rhetoric of persuasion under the pretext that it is the account's acceptability to the patient that is therapeutically effective" (p. 862).

Ricoeur suggests that there are some general hypotheses about how the mind works and how it develops that exist independently of the many narratives that could be constructed—for example, the developing sequence of psychosexual stages or the developing nature of object- or person-relatedness. These general hypotheses can be potentially tested or strongly supported by direct observation or by evidence existing outside of any one particular narrative and outside of psychoanalysis. One advantage of Ricoeur's position is that it provides the clinical infant with greatly needed independent sources of information to help examine the implicit general hypotheses that go into the construction of the life narrative. The observed infant might be such a source.

I am in full agreement with Ricoeur's position, which provides much of the rationale for proceeding as I do in this book, but with the understanding that this position applies to metapsychology, or the constraints of developmental theory, not to any one patient's reconstructed felt-history.

There is a third consideration that bears on this issue of contrasting, partially incompatible viewpoints. The current scientific Zeitgeist has a certain persuasive and legitimizing force in determining what is a reasonable view of things. And at this moment the Zeitgeist favors observational methods. The prevailing view of the infant has shifted dramatically in the past few years and will continue to shift. It will ultimately be a cause for uneasiness and questioning if the psychoanalytic view of infancy becomes too divergent and contradictory relative to the observational approach. As related fields, presum-
ably about the same subject matter even though from different perspectives, they will not tolerate too much dissonance, and it currently appears that it is psychoanalysis that will have to give way. (This position may seem overly relativistic, but science advances by shifting paradigms about how things are to be seen. These paradigms are ultimately belief systems.) Thus, the mutual influence between the observed and the clinical infants will result both from a direct confrontation about those specific issues that the two views can contest, as implied by Ricoeur, and from the evolving sense of the nature of infancy, to which both views contribute. This process will gradually determine what feels acceptable, tenable, and in accord with common sense.

The observed infant is also a special construct, a description of capacities that can be observed directly: the ability to move, to smile, to seek novelty, to discriminate the mother’s face, to encode memories, and so on. These observations themselves reveal little about what the “felt quality” of lived social experience is like. Moreover, they tell us little about higher organizational structures that would make the observed infant more than a growing list of capacities that is organized and reorganized. As soon as we try to make inferences about the actual experiences of the real infant—that is, to build in qualities of subjective experience such as a sense of self—we are thrown back to our own subjective experience as the main source of inspiration. But that is exactly the domain of the clinical infant. The only storehouse of such information is our own life narratives, what it has felt like to live our own social lives. Here, then, is the problem: the subjective life of the adult, as self-narrated, is the main source of inference about the infant’s felt quality of social experience. A degree of circularity is unavoidable.

Each view of the infant has features that the other lacks. The observed infant contributes the capacities that can be readily witnessed; the clinical infant contributes certain subjective experiences that are fundamental and common features of social life. The partial joining of these two infants is essential for three

2. The potential dangers of adultomorphizing are real. Therefore, it is important that the subjective experiences chosen are not those seen exclusively or particularly in adult psychopathological states, nor those that come to be acceptable and reasonable only after much psychodynamic self-exploration. They should be apparent to anyone and a normal part of common experience.
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reasons. First, there must be some way that actual happenings—that is, observable events ("mother did this, and that . . .")—become transformed into the subjective experiences that clinicians call intrapsychic ("I experienced mother as being . . ."). It is this crossover point that involves the participation of both the observed infant and the clinical infant. While the two perspectives do not overlap, they do touch one another at certain points to create an interface. One can never understand the genesis of psychopathology without this interface. Second, the therapist who is better acquainted with the observed infant may be in a position to help patients create more appropriate life narratives. Third, the observer of infants who is better acquainted with the clinical infant may be prompted to conceive of new directions for observation.3

Perspectives on the Subject Matter of Development

THE PSYCHOANALYTIC PERSPECTIVE

Developmental psychology views the maturation of new capacities (such as hand-eye coordination, recall memory, and self-awareness) and their reorganization as the appropriate subject matter of developmental shifts. For the sake of clinical utility and a subjective account, psychoanalysis has had to take a further step and define the progressive reorganizations in terms of larger organizing principles of development, or mental life. Freud's developmental progression from oral to anal to genital stages was seen as the sequential reorganization of drive, or the nature of the id. Erikson's developmental progression from trust to autonomy to industry was seen as the sequential reorganization of ego and character structures. Similarly, Spitz's progression of organizing principles concerned a sequential restructuring of ego precursors. Mahler's developmental progression

3. Even those who are decidedly committed to the approach of psychopharmacology will ultimately (when further advances in neurochemical understanding have been made and assimilated) have to re-confront or confront for the first time the level of subjective experience in the light of their new understandings. At the moment, the level of subjective experience may seem like a thing of the past from the chemical viewpoint, but soon enough it will be the wave of the future, if and when (and only if and when) chemical psychiatry fulfills its promise.
from normal autism to normal symbiosis to separation-individuation concerned the restructuring of ego and id, but in terms of the infant's experience of self and other. Klein's developmental progression (depressive, paranoid, and schizoid positions) also concerns the restructuring of the experience of self and other, but in a very different manner.

The developmental account described in this book, in which new senses of the self serve as organizing principles of development, is closest to the accounts of Mahler and Klein in that its central concern, like theirs, is for the infant's experience of self and other. The differences lie in what the nature of that experience is thought to be, in the order of the developmental sequence, and in my focus on the development of the sense of self, not encumbered with or confused with issues of the development of the ego or id.

Psychoanalytic developmental theories share another premise. They all assume that development progresses from one stage to the next, and that each stage is not only a specific phase for ego or id development but also specific for certain proto-clinical issues. In effect, developmental phases concern the infant's initial dealing with a specific type of clinical issue that can be seen in pathological form in later life. This is what Peterfreund (1978) and Klein (1980) mean by a developmental system that is both pathomorphic and retrospective. More specifically, Peterfreund speaks of "two fundamental conceptual fallacies, especially characteristic of psychoanalytic thought: the adultomorphization of infancy and the tendency to characterize early states of normal development in terms of hypotheses about later states of psychopathology" (p. 427).

It is in this way that Freud's phases of orality, anality, and so on refer not only to stages of drive development but to potential periods of fixation—that is, to specific points of origin of pathology—that will later result in specific psychopathological entities. Similarly, Erikson sought in his developmental phases the specific roots of later ego and character pathology. And in Mahler's theory, the need to understand later clinical phenomena such as childhood autism, symbiotic psychosis of childhood, and overdependency initially led to postulating the occurrence of these entities in some preliminary form earlier in development.

These psychoanalysts are developmental theorists working backward in time. Their primary aim was to aid in understanding the devel-
opment of psychopathology. This in fact was a task of therapeutic urgency, a task that no other developmental psychology was dealing with. But it forced them to position pathomorphically chosen clinical issues seen in adults in a central developmental role.

In contrast, the approach taken here is normative rather than pathomorphic and prospective rather than retrospective. While disruptions in the development of any sense of self may prove to be predictive of later pathology, the different senses of self are designed to describe normal development and not to explain the ontogeny of pathogenic forms (which does not mean that ultimately they may not be helpful in that task).

Psychoanalytic theories make yet another assumption, that the pathomorphically designated phase in which a clinical issue is being worked on developmentally is a sensitive period in ethological terms. Each separate clinical issue, such as orality, autonomy, or trust, is given a limited time slot, a specific phase in which the designated phase-specific clinical issue "comes to its ascendancy, meets its crisis, and finds its lasting solution through a decisive encounter with the environment" (Sander 1962, p. 5). In this way each age or phase becomes a sensitive, almost critical, period for the development of a single phase-specific clinical issue or personality feature. Freud's, Erikson's, and Mahler's sequences are examples par excellence. In such systems, each issue (for example, symbiosis, trust, or orality) ends up with its own distinct epoch. The result is a parade of specific epochs, in which each of the most basic clinical issues of life passes by the grandstand in its own separate turn.

Do these clinical issues really define age-specific phases? Does the succession of different predominant clinical issues explain the quantum leaps in social relatedness that observers and parents readily note? From the point of view of the developmental psychologist, there are serious problems with using clinical issues to describe developmental phases meaningfully. The basic clinical issues of autonomy and independence provide a good example.

How does one identify the crucial events that might define a phase that is specific to the issues of autonomy and independence? Both Erikson (1950) and Freud (1905) placed the decisive encounter for this clinical issue around the independent control of bowel functioning at about twenty-four months. Spitz (1957) placed the decisive encounter in the ability to say "no" at fifteen months or so. Mahler
(1968, 1975) considered the decisive event for autonomy and independence to be infants' capacity to walk, to wander away from mother on their own initiative, beginning at about twelve months. The timing of these three different decisive encounters disagrees by a whole year, half the two-year-old child's life. That is a big disagreement. Which author is right? They are all right, and that is both the problem and the point.

In fact, there are other behaviors that can equally well be identified as criteria for autonomy and independence. The interaction between mother and infant as carried on with gaze behavior during the three-to-six-month period, for instance, is strikingly like the interaction between mother and infant as carried out with locomotor behaviors during the twelve- to eighteen-month period. During the three- to five-month period, mothers give the infant control—or rather the infant takes control—over the initiations and terminations of direct visual engagement in social activities (Stern 1971, 1974, 1977; Beebe and Stern 1977; Messer and Vietze, in press). It must be recalled that during this period of life the infant cannot walk and has poor control over limb movements and eye-hand coordination. The visual-motor system, however, is virtually mature, so that in gazing behavior the infant is a remarkably able interactive partner. And gazing is a potent form of social communication. When watching the gazing patterns of mother and infant during this life period, one is watching two people with almost equal facility and control over the same social behavior.4

In this light, it becomes obvious that infants exert major control over the initiation, maintenance, termination, and avoidance of social contact with mother; in other words, they help to regulate engagement. Furthermore, by controlling their own direction of gaze, they self-regulate the level and amount of social stimulation to which they are subject. They can avert their gaze, shut their eyes, stare past, become glassy-eyed. And through the decisive use of such gaze behaviors, they can be seen to reject, distance themselves from, or defend themselves against mother (Beebe and Stern 1977; Stern

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4. The same can of course be said of any dyad of infant and caregiver. Throughout this book, "mother," "parent," and "caregiver" are generally used interchangeably to mean the primary caregiver. Similarly, "the dyad" denotes infant and primary caregiver. The exceptions should be fairly obvious: references to breast-feeding, to specific cases, and to research focusing on maternal behavior.
1977; Beebe and Sloate 1982). They can also reinitiate engagement and contact when they desire, through gazing, smiling, and vocalizing.

The manner in which infants regulate their own stimulation and social contact through gaze behavior is quite similar, for the generic issue of autonomy and independence, to the manner in which they accomplish the same thing nine months later by walking away from and returning to mother's side. Why, then, should we not consider the period from three to six months also as phase-specific for the issue of autonomy and independence, both as displayed in overt behavior and as experienced subjectively?

Mothers know quite well that infants can assert their independence and say a decisive "NO!" with gaze aversions at four months, gestures and vocal intonation at seven months, running away at fourteen months, and language at two years. The basic clinical issue of autonomy or independence is inherently operating in all social behaviors that regulate the quantity or quality of engagement. The decision, then, as to what constitutes a decisive event that makes autonomy or independence the phase-specific issue appears to have more to do with maturational leaps in cognitive level or motor capacities that are outside the considerations of autonomy and independence per se. It is these abilities and capacities that are the real desiderata in each theoretician's definition of a phase. And each theoretician uses a different criterion.

Those who are persuaded that there do exist basic clinical issues, time-locked specific phases, would argue that all clinical issues are of course being negotiated all of the time, but that there is still the feature of predominance, that one life-issue is relatively more prominent at one life period. Certainly, at a given point in development the new behaviors that are used to conduct ongoing issues can be more dramatic (for example, the forms that autonomy and independence take in the "terrible twos"), and these new forms can also require more socializing pressure that attracts much more attention.

5. Messer and Vietze (in press) point out that the dyadic gazing patterns become far less regulatory of the interaction at one year, when infants have acquired other ways (such as locomotion) of regulating the interaction and their own level of tension.

6. One could argue that not until twelve months do infants have sufficient intentionality, object permanence, and other cognitive capacities to make the notion of autonomy or independence meaningful. But one could also argue that not until eighteen to twenty-four months do infants have enough symbolic functions or self-awareness to make these notions meaningful. Both arguments have been made.
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to them. But the need for more socializing pressure is largely culturally determined.7 The “terrible twos” are not terrible in all societies.

It therefore seems likely that a relative predominance of protoclinical issues in a particular age period is illusory and emerges from theoretical, methodological, or clinical needs and biases in conjunction with cultural pressures. It is in the eyes of the beholder, not in the infant’s experience. Further, if one picks out one basic life-issue and devotes a developmental epoch to its decisive resolution, the picture of the developmental process will necessarily be distorted. It will portray potential clinical narratives, not observable infants. There are no convincing grounds, from the observational point of view, for considering basic clinical issues as adequate overall definers of phases or stages of development.8

Clinical issues are issues for the life span, not phases of life. Consequently, clinical issues fail to account for the developmental changes in the social “feel” of the infant or in the infant’s subjective perspective about social life.

There is an additional problem with making these traditional clinical-developmental issues the subject matter of sequential sensitive phases of life. In spite of the fact that these views have been prevalent for many decades, there have as yet been no prospective longitudinal studies that support the very clear predictions of these theories. Psychological insults and trauma at a specific age or phase should result in predictably specific types of clinical problems later on. No such evidence exists.9

7. Sameroff (1983) provides a systems-theory model for explaining the interaction between society and the parent-infant dyad in determining “predominance” of an issue, that is, how events at the societal level can make an issue more salient for the dyad.

8. Pine (1981) has offered a compromise accounting for the fact commonly observed by mothers that infants are “in” many clinical issue-specific phases at the same time (for example, attaching, while becoming autonomous, while developing mastery). He suggests that the infant has many significant “moments” in any day or hour when different clinical issues are dominant. The problem with this solution is twofold. Significant “moments” appear to be chosen partly on the basis of preconception about the predominant phase (that is, circularly), and such moments are organized around high-intensity experiences. The privileged organizing capacity of high-intensity compared to medium- or low-intensity moments is an open empirical issue. Nonetheless, the impressions that led Pine to this particular solution attest to the widespread recognition of the problem.

9. One of the problems with the implicit or explicit predictions that psychoanalytic theory has made about the ontogeny of pathology is that they were perhaps too specific. Recent thinking about developmental psychopathology (Cicchetti and Schnieder-Rosen, in press; Stroufe and Rutter 1984) stresses that the manifestations of pathology may be very different at
THE QUESTIONS AND THEIR BACKGROUND

For those who observe infants directly, there certainly do appear to be phases of development. These phases, however, are not seen in terms of later clinical issues, but rather in terms of current adaptive tasks that arise because of maturation in the infant's physical and mental capacities. The result is a progression of developmental issues that the dyad must negotiate together for adaptation to proceed. It is from this perspective that Sander (1964) has described the following phases: physiological regulation (zero to three months); regulation of reciprocal exchange, especially social-affective modulation (three to six months); the joint regulation of infant initiation in social exchanges and in manipulating the environment (six to nine months); the focalization of activities (ten to fourteen months); and self-assertion (fifteen to twenty months). Greenspan (1981) has evolved a somewhat similar sequence of stages, except that his stray further from readily observable behavior and incorporate some of the abstract organizing principles of psychoanalysis and attachment theory. The stages he proposes are thus more heterogeneous: homeostasis (zero to three months); attachment (two to seven months); somatopsychological differentiation (three to ten months); behavioral organization, initiative, and internalization (nine to twenty-four months); and representational capacity, differentiation and consolidation (nine to twenty-four months).

Most observers of parent-infant interactions would agree that such descriptive systems more or less capture many of the important developmental changes. While several specifics of these descriptive systems are arguable, the systems are helpful clinically in evaluating and treating parent-infant dyads in distress. The central point here is not the validity of these descriptions but the nature of the perspective they take. They view the dyad as the unit of focus and they view it in terms of adaptive tasks. This is at a great remove from any consideration of the infant's likely subjective experience. Infants go about their business of growing and developing, and abstract entities such as homeostasis, reciprocal regulation, and the like are not a

different ages. Even most normal developmental issues are now thought to undergo considerable transformation in manifestation across age. This has been an accumulating impression about the paradox of developmental discontinuity within continuity (Waddington 1940; Sameroff and Chandler 1975; Ragan, Kearsley, and Zelazo 1978; McCall 1979; Garmenzy and Rutter 1983; Hinde and Bateson 1984).
conceivably meaningful part of their subjective social experience. Yet it is exactly with the infant's subjective experience that we are most concerned in this inquiry.

Attachment theory as it has grown from its origins in psychoanalysis and ethology (Bowlby 1969, 1973, 1980) to include the methods and perspectives of developmental psychology (Ainsworth and Wittig 1969; Ainsworth et al. 1978) has come to embrace many levels of phenomena. At various levels, attachment is a set of infant behaviors, a motivational system, a relationship between mother and infant, a theoretical construct, and a subjective experience for the infant in the form of "working models."

Some levels of attachment, such as the behavior patterns that change to maintain attachment at different ages, can be seen readily as sequential phases of development, while others, such as the quality of the mother-infant relationship, are life-span issues (Sroufe and Waters 1977; Sroufe 1979; Hinde 1982; Bretherton and Waters, in press).

Most attachment theorists, perhaps because of their grounding in academic psychology, have been slow to pick up on Bowlby's notion that while attachment is a perspective on evolution, on the species and on the individual dyad, it is also a perspective on the subjective experience of the infant in the form of the infant's working model of mother. Only recently have researchers readdressed Bowlby's notion of the working model of the mother in the infant's mind. Currently several researchers (Bretherton, in press; Main and Kaplan, in press; Osofsky 1985; Sroufe 1985; Sroufe and Fleeson 1985) are reaching further to make the construct of attachment meaningful at the level of the infant's subjective experience.10

THE PERSPECTIVE OF THE DEVELOPING SENSES OF THE SELF

The present account, even in the form of a working hypothesis, shares many features with both traditional psychoanalytic theory and attachment theory. Higher order constructs are needed to serve as the organizing principles of development. In this respect, the account is completely in line with both theories. It differs from them in that the organizing principle concerns the subjective sense of self. While

10. Attachment theory is both normative and prospective. Yet interestingly it is proving to be specifically predictive—and strongly so—of later behaviors, some of which are pathological. (The research findings will be discussed in detail in chapters 5 and 9.)
Self Psychology is emerging as a coherent therapeutic theory that places the self as a structure and process at the center, there have as yet been no systematic attempts to consider the sense of self as a developmental organizing principle, although some speculations in that direction have been made (for example, Tolpin 1971, 1980; Kohut 1977; Shane and Shane 1980; Stechler and Kaplan 1980; Lee and Noam 1983; Stolerow et al. 1983). And it is not yet clear how compatible the present developmental view will be with the tenets of Self Psychology as a clinical theory for adults.

Certainly, Mahler and Klein and the object relations school have focused upon the experience of self-and-other, but mainly as the fall out of, or secondary to, libidinal or ego development. Those theorists never considered the sense of self as the primary organizing principle.

This account, centering on the sense of self-and-other, has as its starting place the infant's inferred subjective experience. It is unique in that respect. Subjective experiences themselves are its main working parts, in contrast to the main working parts of psychoanalytic theories, which are the ego and id from which subjective experiences are derived.

The Developmental Progression of the Sense of Self

As new behaviors and capacities emerge, they are reorganized to form organizing subjective perspectives on self and other. The result is the emergence, in quantum leaps, of different senses of the self. These will be outlined briefly here. In part 2 separate chapters are devoted to each.

There is, for one, the physical self that is experienced as a coherent, willful, physical entity with a unique affective life and history that belong to it. This self generally operates outside of awareness. It is taken for granted, and even verbalizing about it is difficult. It is an experiential sense of self that I call the sense of a core self. The sense of a core self is a perspective that rests upon the working of many

11. The sense of a core self includes the phenomena that are encompassed in the term "body ego" as used in the psychoanalytic literature. However, it includes more than that, and it is conceptualized differently without recourse to the entity ego. The two are not strictly comparable. It is also more than a sensorimotor schema, since it includes affective features.
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interpersonal capacities. And when this perspective forms, the subjective social world is altered and interpersonal experience operates in a different domain, a domain of core-relatedness. This developmental transformation or creation occurs somewhere between the second and sixth months of life, when infants sense that they and mother are quite separate physically, are different agents, have distinct affective experiences, and have separate histories.

That is only one possible organizing subjective perspective about the self-and-other. Sometime between the seventh and ninth months of life, infants start to develop a second organizing subjective perspective. This happens when they “discover” that there are other minds out there as well as their own. Self and other are no longer only core entities of physical presence, action, affect, and continuity. They now include subjective mental states—feelings, motives, intentions—that lie behind the physical happenings in the domain of core-relatedness. The new organizing subjective perspective defines a qualitatively different self and other who can “hold in mind” unseen but inferable mental states, such as intentions or affects, that guide overt behavior. These mental states now become the subject matter of relating. This new sense of a subjective self opens up the possibility for intersubjectivity between infant and parent and operates in a new domain of relatedness—the domain of intersubjective relatedness—which is a quantum leap beyond the domain of core-relatedness. Mental states between people can now be “read,” matched, aligned with, or attuned to (or misread, mismatched, misaligned, or misattuned). The nature of relatedness has been dramatically expanded. It is important to note that the domain of intersubjective relatedness, like that of core-relatedness, goes on outside of awareness and without being rendered verbally. In fact, the experience of intersubjective relatedness, like that of core-relatedness, can only be alluded to; it cannot really be described (although poets can evoke it).

The sense of a subjective self and other rests upon different capacities from those necessary for a sense of a core self. These include the capacities for sharing a focus of attention, for attributing intentions and motives to others and apprehending them correctly, and for attributing the existence of states of feeling in others and sensing whether or not they are congruent with one’s own state of feeling.

At around fifteen to eighteen months, the infant develops yet a
third organizing subjective perspective about self and other, namely
the sense that self (and other) has a storehouse of personal world
knowledge and experience ("I know there is juice in the refrigerator,
and I know that I am thirsty"). Furthermore, this knowledge can be
objectified and rendered as symbols that convey meanings to be
communicated, shared, and even created by the mutual negotiations
permitted by language.

Once the infant is able to create shareable meanings about the self
and the world, a sense of a verbal self that operates in the domain of
verbal relatedness has been formed. This is a qualitatively new domain
with expanding, almost limitless possibilities for interpersonal hap-
penings. Again, this new sense of self rests on a new set of capacities:
to objectify the self, to be self-reflective, to comprehend and produce
language.

So far we have discussed three different senses of the self and
other, and three different domains of relatedness that develop between
the age of two months and the second year of the infant’s life.
Nothing has yet been said about the period from birth to two
months. It can now be filled in.

During this earliest period, a sense of the world, including a sense
of self, is emergent. Infants busily embark on the task of relating
diverse experiences. Their social capacities are operating with vigorous
goal-directedness to assure social interactions. These interactions
produce affects, perceptions, sensorimotor events, memories, and
other cognitions. Some integration between diverse happenings is
made innately. For instance, if infants can feel a shape by touching
an object, they will know what the object should look like without
ever having seen it before. Other integrations are not so automatic
but are quickly learned. Connectedness forms rapidly, and infants
experience the emergence of organization. A sense of an emergent self
is in the process of coming into being. The experience is that of the
emergence of networks becoming integrated, and we can refer to its
domain as the domain of emergent relatedness. Still, the integrative
networks that are forming are not yet embraced by a single organizing
subjective perspective. That will be the task of the developmental
leap into the domain of core-relatedness.

The four main senses of self and the domains of relatedness that
have been described will occupy much of this book. The four senses
of the self conform in their time of emergence to the major
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developmental shifts that have been noted. The change in the social feel of an infant with the emergence of each sense of self is also in accord with the nature of these shifts. So is the predominant “action” between parent and child, which shifts from the physical and actional to the mental events that underlie the overt behavior and then to the meanings of events. Before examining these senses and domains further, however, we must address the issue of sensitive periods and make clear that we are dealing not only with successive phases but also with simultaneous domains of self-experience.

As the four domains of relatedness develop successively, one after the other, what happens to each domain when the next comes along? Does each sense of self remain intact in the presence of the new ones, so that they coexist? Or does the emergence of each new sense of self eclipse the existing ones, so that sequential phases wax and wane?

The traditional picture of both the clinical infant and the observed infant leans toward a view of sequential phases. In both developmental systems, the infant’s world view shifts dramatically as each new stage is ushered in, and the world is seen dominantly, if not exclusively, in terms of the organization of the new stage. What happens, then, to the previous phases, to the earlier world views? Either they are eclipsed and drop out or, as Werner (1948) suggests, they remain dormant but become integrated into the emergent organization and thereby lose much of their previous character. As Cassirer (1955) puts it, the advent of a higher stage “does not destroy the earlier phase, rather it embraces it in its own perspective” (p. 477). This also happens in Piaget’s system.

In these developmental progressions of phases, it is possible to return to something like an earlier phase. But special processes and conditions are needed to pull the person back, in developmental time, to experience the world in a manner similar to the way it was experienced earlier. In clinical theories, regression serves that purpose. In Werner and Kaplan’s system (1963), one can move up and down the ontogenetic spiral. These returns to previous and more global modes of experience are thought to occur mainly under conditions of challenge, stress, conflict, failure of adaptation, or fatigue, and in dream states, psychopathological conditions, or drug states. With the exception of these regressions, developing world views are mainly successive and sequential, not simultaneous. Current organizations of
experience subsume earlier ones. They do not coexist with them. This developmental progression is schematized in figure 2.1, in which (a) could represent orality, trust, normal autism; (b) anality, autonomy; (c) genitality, and so on.

This view of development may be the most reasonable when one is considering the developmental progression of certain mental abilities or cognitive capacities, but that is not the present task. We are trying to consider the sense of self as it occurs in interpersonal encounters, and in that subjective sphere simultaneity of senses of the self appears to be closer to common experience. And no extraordinary conditions or processes need be present to permit the movement back and forth between experiences in different domains, that is, between different senses of the self.

An illustration from adult experience will help us to understand this simultaneity of senses of self. Making love, a fully involving interpersonal event, involves first the sense of the self and the other as discrete physical entities, as forms in motion—an experience in the domain of core-relatedness, as is the sense of self-agency, will, and activation encompassed in the physical acts. At the same time it involves the experience of sensing the other's subjective state: shared desire, aligned intentions, and mutual states of simultaneously shifting arousal, which occur in the domain of intersubjective relatedness. And if one of the lovers says for the first time "I love you," the words summarize what is occurring in the other domains (embraced in the verbal perspective) and perhaps introduce an entirely new note about the couple's relationship that may change the meaning of the history that has led up to and will follow the moment of saying it. This is an experience in the domain of verbal relatedness.

What about the domain of emergent relatedness? That is less
readily apparent, but it is present nonetheless. One may, for example "get lost in" the color of the other's eye, as if the eye were momentarily not part of the core other, unrelated to anyone's mental state, newly found, and outside of any larger organizing network. At the instant the "colored eye" comes again to belong to the known other, an emergent experience has occurred, an experience in the domain of emergent relatedness.\textsuperscript{12}

We see that the subjective experience of social interactions seems to occur in all domains of relatedness simultaneously. One can certainly attend to one domain for a while to the partial exclusion of the others, but the others go on as distinct experiences, out of but available to awareness. In fact, much of what is meant by "socializing" is directed at focusing awareness on a single domain, usually the verbal, and declaring it to be the official version of what is being experienced, while denying the experience in the other domains ("unofficial" versions of what is happening). Nonetheless, attention can and does shift with some fluidity from experience in one domain to that in another. For instance, language in interpersonal service is largely the explication (in the verbal domain) of concomitant experiences in other domains, plus something else. If you ask someone to do something, and that person answers "I'd rather not. I'm surprised you asked!" he may at the same time raise his head and throw it back slightly, raise his eyebrows, and look down his nose a bit. The meaning of this nonverbal behavior (which is in the domain of core-relatedness and intersubjective relatedness) has been well rendered in language. Still these physical acts retain distinctive experiential characteristics. Performing or being the target of them involves experiences that reside outside of language itself.

All domains of relatedness remain active during development. The infant does not grow out of any of them; none of them atrophy, none become developmentally obsolete or get left behind. And once all domains are available, there is no assurance that any one domain will necessarily claim preponderance during any particular age period. None has a privileged status all of the time. Since there is an orderly temporal succession of emergence of each domain during develop-

\textsuperscript{12} These emergent experiences are descriptively disassociated from organizing perspectives. However, they are not the product of "disassociation" as a psychic process defined by psychoanalysis any more than is the initial impression of an isolated feature of a work of art viewed in the contemplative mode.
The development described—first emergent, then core, then subjective, then verbal—will inevitably be periods when one or two domains hold predominance by default. In fact, each successive organizing subjective perspective requires the preceding one as a precursor. Once formed, the domains remain forever as distinct forms of experiencing social life and self. None are lost to adult experience. Each simply gets more elaborated. It is for this reason that the term *domains* of relatedness has been chosen, rather than *phases* or *stages.* The developmental situation as described is depicted in figure 2.2.

We can now return to the issue of sensitive periods. It seems that the initial period of formation for many developing psychological (and neurological) processes is a relatively sensitive one in the sense that an event occurring early will have a greater impact and its influence will be more difficult to reverse than an event occurring later. This general principle presumably applies to the formative

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13. "Domains" seems preferable over "levels," because "levels" implies a hierarchical status that is accurate ontogenetically but need not pertain in the sphere of social life as subjectively experienced.
phase of each sense of the self. The timing of the formative phases is schematized in figure 2.3.

This view permits us to consider the formative phase for each sense of self as a sensitive period. The clinical implications of doing so will be considered in chapters 9 and 11.

What happens to the important clinical issues of autonomy, orality, symbiosis, individuation, trust, attachment, mastery, curiosity, and so on—the issues that occupy center stage in the therapeutic creation of the clinical infant? These clinical issues do not drop out of the picture at all. They simply hand over their role as primary organizers of subjective experience to the changing senses of self. Life-course clinical issues such as autonomy and attachment are worked on equally in all the domains of relatedness that are available at any given time. During each formative phase of relatedness, the arena of interpersonal action in which the issues get played out will change as the self and other are sensed as different. Accordingly, different forms of the same life-course issue develop in succession: for example,
physical intimacy during core-relatedness, subjective (empathic-like) intimacy during intersubjective relatedness, and the intimacy of shared meanings during verbal relatedness. Thus, each life-course clinical issue has its own developmental line, and a slightly different contribution to that developmental line is made in each domain of relatedness.  

In summary, the subjective social life of the infant will be viewed as having the following characteristics. The infant is endowed with observable capacities that mature. When these become available, they are organized and transformed, in quantum mental leaps, into organizing subjective perspectives about the sense of self and other. Each new sense of self defines the formation of a new domain of relatedness. While these domains of relatedness result in qualitative shifts in social experience, they are not phases; rather, they are forms of social experience that remain intact throughout life. Nonetheless, their initial phase of formation constitutes a sensitive period of development. Subjective social experience results from the sum and integration of experience in all domains. The basic clinical issues are seen as issues for the life span and not as issues of developmental phases. A different contribution is made to the ontogeny of the developmental lines of all clinical issues as each domain of self-experience emerges.

With this much of the point of view and approach in hand, we can turn in the next section of this book to a closer look at the four senses of self and their four domains of relatedness. We will bring together the observational and clinical evidence that argues for this view of the development of the infant’s subjective social experience.

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14. This treatment of lines of development is an extreme version of the same idea put forward by A. Freud (1965). However, she did not fully abandon the notion of libidinal phase specificity. The present suggestion is a rejection of that notion. Here, all clinical issues become developmental lines, and no hidden or ultimately clinical issues remain anchored to any given developmental epochs.
PART II

THE FOUR SENSES OF SELF