Psychoanalytic Psychology
2014, Vol. 31, No. 3, 297–313

0736-9735/14/$12.00 http://dx.doi.org/10.1037/a0036866

PATIENTS' SELFOBJECT NEEDS IN PSYCHODYNAMIC PSYCHOTHERAPY: *How They Relate to Client Attachment, Symptoms, and the Therapy Alliance*

Cheri L. Marmarosh, PhD and Sandra Mann, PsyD
The George Washington University

Eighty-three patients in psychodynamic psychotherapy completed the Selfobject Needs Inventory (SONI), a measure of adult attachment, a measure of working alliance, and the Symptom Checklist-Revised between the third and fifth sessions of therapy. Replicating previous nonclinical research, a positive correlation was found between avoidance of selfobject needs and adult romantic attachment avoidance. In addition, the results revealed a positive relationship between hunger for mirroring and attachment anxiety and hunger for mirroring and self-reported symptoms. As expected, there were negative correlations between avoidance of twinship needs and symptoms and avoidance of idealization and symptoms. When selfobject needs were pitted against attachment in hierarchical regression, only attachment anxiety and avoidance contributed significant variance in the prediction of symptoms. We did not find any significant relationship between selfobject needs and the early alliance. Post hoc hierarchical regression analysis revealed that selfobject needs contributed significant variance in the prediction of the therapy bond and attachment anxiety and avoidance did not. Implications of the current research are discussed along with recommendations for future study.

Keywords: self psychology, selfobject needs, attachment styles, psychotherapy research

Despite much theoretical literature describing the overlap between self psychology and attachment theory (Carr & Cortina, 2011; Cortina & Marrone, 2003; Shane, Shane, & Gales, 1997; Schore, 2002), only two empirical papers have been published that highlight

This article was published Online First June 2, 2014.

Cheri L. Marmarosh, PhD and Sandra Mann, PsyD, Professional Psychology, The George Washington University.

Correspondence concerning this article should be addressed to Cheri L. Marmarosh, PhD, Professional Psychology Program, The George Washington University, 1922 F Street, Suite 103, Washington, DC 20052. E-mail: marmaros@gwu.edu

the relationship between Kohut's (1984) selfobject needs and Bowlby's (1988) attachment dimensions. (Banai, Mikulincer, & Shaver, 2005; Lopez et al., 2013). Although both of these studies found empirical support for the relationship between selfobject needs and adult attachment, neither study focused on psychotherapy patients and how these factors relate to clinically relevant phenomenon such as patients' report of symptoms and the early therapy alliance. The current article aims to replicate prior findings demonstrating a relationship between attachment dimensions, anxiety and avoidance, and selfobject needs, but it also aims to explore how attachment and selfobject needs uniquely contribute to client reported symptoms and client perceived therapy relationship.

Kohut's Self Psychology

Kohut (1971, 1977, 1984) emphasized how early caregiving experiences play an important role in fostering the development of a cohesive sense of self by meeting critical developmental needs, needs he referred to as *selfobject needs.* According to Kohut (1984), there are three major types of selfobject needs that influence the developing self: mirroring, idealizing, and twinship. A healthy mirroring selfobject experience, such as being the gleam in the parent's eye, facilitates self-esteem, ambitions, and the ability to assert oneself later in life. Unlike mirroring needs, idealizing selfobject needs stem from the desire to rely on or merge with an idealized other in times of stress, similar to a desire to seek the resources of a secure attachment figure. When idealizing selfobject needs are met, they foster a healthy sense of ideals and internal values and promote self-soothing and emotion regulation. Selfobject needs for twinship include our need to belong, to be acknowledged as a fellow human being, and to feel connected to a similar other. Twinship selfobject needs that are met facilitate a sense of connection to a larger group, intimacy, and feelings of belongingness.

Kohut and Wolf (1978) argue that early deficits in mirroring, idealizing, and twinship lead to disorders of the self. For instance, failure to have one's selfobject needs met adequately may activate either hunger or avoidance of those needs in adulthood. A child with absent, neglectful, or inconsistent caregivers who do not adequately mirror the child may foster the development of an adult who is mirror hungry and seeks out others to facilitate a feeling of being special.

Selfobject deficits have been linked to a wide range of psychological problems, including pathological narcissism, difficulty regulating emotions, and deficits in interpersonal functioning (Kohut, 1984). The degree and type of the resulting psychopathology, however, depends on the developmental stage in which these primary needs were arrested (Fonagy & Target, 1997; Kohut & Wolf, 1978). At the extreme, the arrest occurs very early and precedes the awareness of selfobjects. At the opposite extreme, neurotic organizations involve individuals struggling to live up to their ideals. Moderate deficits lead to a failure to internalize realistic ambition or mature ego ideals, leading to fears of fragmentation and heightened vulnerability to criticism, failure, negative emotions, pessimistic thoughts, and loneliness (Kohut, 1971). Personality disorders, such as narcissistic and borderline personality disorders, are thought to result from these threats to the self.

In treatment, the therapist, similar to the early caregiver, serves multiple selfobject functions (Rowe & MacIsaac, 1991) and an important aspect of treatment is identifying these selfobject transferences within the therapy process as they develop. Awareness of the patient's unmet selfobject needs becomes evident when the therapist is attuned to the many ways the patient both expresses these needs in the session and responds when these

selfobject longings are frustrated. Mirroring needs may be expressed as the wish for validation from the therapist, or the "gleam" in the therapist's eye. Idealizing needs may be expressed when the patient admires the therapist and looks to the therapist to gain a sense of strength, emotion regulation, or protection. Feeling similar to or connected to the therapist may satisfy twinship needs. In addition to the therapist identifying these selfobject transferences when they are expressed in the session, it is critical for the therapist to be aware of the injuries that ensue when they are not met (Kohut, 1977). Despite the many followers of self psychology, we could find no empirical articles that explored how selfobject needs influence the alliance, develop over time, and relate to treatment outcome.

Measurement of Selfobject Needs

One of the possible reasons behind the insufficient research has been the lack of a valid measure to assess selfobject needs. Fortunately, Banai, Mikulincer, and Shaver (2005) developed an instrument that assesses the central constructs of Kohut's theory (1984), the Selfobject Needs Inventory (SONI). The researchers operationalized the three core selfobject needs that Kohut described: mirroring, idealizing, and twinship. Results of their seven validity studies revealed that there were significant relationships between selfobject needs and measures of narcissism, well-being, and personality functioning. The researchers found support for their instrument's factor structure, test–retest reliability, and associations to measures assessing similar constructs such as attachment style. Both Banai et al. (2005) and Lopez et al. (2013) found significant correlations between selfobject needs and the dimensions of attachment anxiety and avoidance in nonclinical populations.

Selfobject Needs and Attachment Theory: Similarities

It is not surprising that selfobject needs and attachment dimensions correlate in both empirical studies (Banai et al., 2005; Lopez et al., 2013). Kohut's theory of the self (Kohut, 1984) and Bowlby's (1969) attachment theory emphasize the early caregiving relationship and how it has a profound impact on the development of a healthy sense of self (Schore, 2002). Both theorists also suggest that the responsiveness of the caregiver will influence how the child develops into an adult and how the adult will respond in intimate relationships. Although Kohut focused on three selfobject transferences that evolve from the relationship with the caregiver (mirroring, idealizing, and twinship), Bowlby focused on automatic emotion regulating strategies that evolve as a result of the attachment relationship, hyperactivation and deactivation. Hyperactivation is said to be caused by having inconsistent or unreliable caregiving which leaves the infant anxious and preoccupied with garnering safety from the caregiver at the expense of exploration. Ainsworth, Blehar, Waters, and Wall (1978) describes infants that make intense efforts to cling to the caregiver in order to satisfy needs for safety, and seem quite sensitive to any distance imposed between them. These more anxious individuals, like those who are seeking another to idealize, tend to seek reassurance from others and are concerned with maintaining proximity to the attachment figure.

Deactivation, on the other hand, is said to be caused by emotional neglect and shaming responses to early dependency needs (Bowlby, 1969). The infant who engages in deactivation is said to have more of a dismissing attachment style because the infant adapts to the caregiving environment by splitting off dependency and emphasizing self- sufficiency. Ainsworth et al. (1978) description of attachment avoidance demonstrates this deactivat-

ing strategy. Even though the child is physiologically distressed during separation from the caregiver, engagement with the attachment figure is avoided when the caregiver is reunited with the child. The deactivation suppresses the fight or flight response and over time minimizes shame and distress (Schore, 2002).

Banai et al. (2005) noted the similarities between Kohut's and Bowlby's theories and relied on a measure of attachment to test the validity of the SONI. They expected that the three selfobject needs and the dimensions of attachment anxiety and avoidance would correlate. As hypothesized, they found that hunger for selfobject needs was positively correlated with attachment anxiety and fears of rejection. Specifically, hunger for unmet selfobject needs resembled the reaction of anxiously attached individuals who hyperactivate their attachment responses in an attempt to elicit more of the others' love and caregiving. In addition, avoidance of selfobject needs was positively correlated with attachment avoidance and minimization of dependency on romantic partners to protect the self. That is, avoidance of selfobject needs was related to deactivation of romantic attachment needs and defensive efforts to avoid closeness and dependency. They also found that hunger for mirroring and twinship needs were related to less self-cohesiveness and self-worth.

More recently, Lopez et al. (2013) used the SONI to explore how selfobject needs related to attachment in college students, and they found that selfobject needs and self-esteem regulating processes predicted different attachment dimensions. Need for mirroring and avoidance of idealization/twinship uniquely predicted attachment anxiety while only avoidance of idealization/twinship predicted attachment avoidance. They argued that using both measures facilitated a deeper understanding of how college students orient themselves to intimate relationships.

Selfobject Needs and Attachment Theory: Distinctions

Although there are many similarities between attachment theory and self psychology, there are also some distinctions. Bowlby argued that the infant was immediately seeking protection and proximity to the caregiver because it was biologically adaptive for survival. The ability for the infant to seek protection while also exploring the environment was best for adaptation. An infant could explore the environment, seek comfort from the caregiver during times of distress, and then resume exploration. On the other hand, an infant with an avoidant caregiver who is nonresponsive or worse, shaming during distress, would better regulated if he or she relied less on the caregiver during times of emotional distress and gained the capacity to self-soothe by detaching from painful emotions. In essence, adapting a deactivating strategy would be beneficial to deal with emotional distress in the absence of an emotion regulating other.

Kohut, unlike Bowlby, was not as focused on biological survival but on the process of developing a cohesive sense of self. He was focused on how the attunement of the caregiver and optimal frustrations fostered the development of a cohesive self that was able to move from primitive selfobject needs to more mature selfobject needs. Kohut would likely argue that a child with an avoidant caregiver would be left alone in the face of painful emotional needs. The rejecting response by the caregiver would lead to deep shame surrounding intense longings that are not only unmet, but likely rejected. This individual would likely reveal more primitive selfobject needs in relationships in the future. According to Lopez et al.'s (2013) findings, the individual with greater attachment avoidance would be more likely to avoid idealizing others and avoid expressing a desire

to belong (twinship). In psychotherapy, this individual would likely try to avoid idealizing the therapist at the risk of being vulnerable and the selfobject transferences would be enacted in the psychotherapy relationship.

The Current Study

A number of studies have supported the importance of the therapeutic relationship and have applied attachment theory to gain a richer understanding of how different patients rely on internal mental representations of self to interpret the therapy experience (see Slade, 1999 and Daniel, 2006, for reviews). Despite the link between attachment and selfobject needs, we could not find any study that has empirically explored how patients' selfobject needs relate to their symptoms or perceptions of the therapeutic relationship. The current study aims to replicate prior findings and extend our understanding of how attachment and selfobject needs relate to one another in treatment. More importantly, the study aims to bring research that is relevant to clinicians who practice psychoanalytically oriented psychotherapy and encourage future studies of psychoanalytic constructs such as selfobject needs.

Hypotheses

1. We expect to replicate findings linking hunger and avoidance of selfobject needs with psychological functioning (Banai et al., 2005). That is, *we expect to find a positive correlation between selfobject need orientations and level of symptoms early in treatment as measured by the Symptom Checklist-90-Revised*. Specifically, we expect a positive relationship between symptoms and patient reported hunger for selfobject needs. The more the patient reveals a hunger for mirroring (Factor 1), idealization (Factor 2), and twinship (Factor 3) the greater his or her report of symptoms. In addition, we predict a negative relationship between avoidance of selfobject needs (Factors 4 and 5) and symptoms. The more the patients avoid selfobject needs, the less they will report symptoms.
2. We expect to replicate prior findings linking selfobject need orientations with attachment insecurity (Banai et al., 2005; Lopez et al., 2013). *We predict that avoidance of selfobject needs will be positively correlated with attachment avoidance*. That is, the more patients deny selfobject needs of idealization and twinship (Factor 5) and mirroring (Factor 4), the more they will deactivate their attachment needs. Additionally, *hunger for selfobject needs will be positively correlated with attachment anxiety*. The more patients endorse needs for closeness and dependency, or hyperactive attachment needs, the more they will reveal desires for mirroring (Factor 1), idealization (Factor 2), and twinship (Factor 3).
3. We want to compare attachment and selfobject needs and how they relate to symptoms. *We expect that attachment dimensions will account for significant variance in symptoms but selfobject needs will also predict unique variance to symptoms, above and beyond attachment dimensions.*

Prior studies have linked attachment anxiety to symptom report, and we expect that selfobject needs also be related to symptoms.

4. We expect that selfobject needs will be significantly related to patient ratings of the therapy relationship. That is, *we expect to find a negative relationship between selfobject avoidance and patient rated working alliance at the third session*. We predict that patients, who minimize and avoid their needs for mirroring (Factor 4) and idealizing/twinship (Factor 5) will report less therapy alliance at the third session. *We expect that selfobject needs will account for unique variance, above and beyond attachment dimensions, in the prediction of the therapy alliance*.

Method

Participants

Eighty-three patients participating in psychotherapy in a mid-Atlantic, psychodynamically oriented training clinic participated. Twenty-eight patients were male and 55 were female. Twelve were African American, six were Asian American, 54 were Caucasian, five were Latino/a, five indicated "other," and one did not respond. The average patient age was 29.41 ($SD = 7.43$) with the youngest patient being 19 and the oldest being 60. Patients were seeking treatment for a wide range of disorders that included Axis I and Axis II diagnoses. Actively psychotic patients, patients in crisis, or patients who were not able to participate in research for some reason were not asked to participate in the study.

Therapists were second- and third-year doctoral students in weekly supervision with psychodynamic and psychoanalytic practitioners in the field. As such, treatment orientations were not manualized and varied among therapists, although long-term dynamic psychotherapy was encouraged.

Measures

Selfobject Needs

Selfobject needs were measured using the SONI (Banai et al., 2005). The SONI is a 38-item self-report measure based on Kohut's (1971, 1977) conceptualization of selfobject needs for mirroring, idealization, and twinship. Mirroring refers to the need for chronic approval and recognition. Idealization refers to needs to identify with powerful others. Twinship refers to the need for social belonginess. Items were constructed to measure the amount of avoidance or need for mirroring ("I don't function well in situations where I receive too little attention"), idealization ("I am attracted to successful people") and twinship ("I feel stronger when I have people around who are dealing with similar problems"). Participants were asked to read each item and to rate, on a 7-point scale, the extent the items were self-reflective. Alpha coefficients for the subscales were .76 for need of mirroring, .75 for avoidance of mirroring, .77 for need of idealization, .76 for avoidance of twinship and idealization, and .70 for need of twinship. The alpha for the avoidance of twinship was marginal but was included based on George and Mallery (2003) who suggest that alphas above .7 are acceptable. Lopez et al. (2013) found a similar alpha coefficient for this subscale.

Attachment

Adult attachment was measured using the Experiences in Close Relationships Scale (ECR; Brennan, Clark, & Shaver, 1998), a 36-item self-report measure that asks participants to agree or disagree on a 7-point scale. The avoidance subscale measures comfort with emotional closeness, with items such as, "I prefer not to show others how I feel deep down." The anxiety subscale assesses the degree to which respondents fear that they will be rejected, neglected, or abandoned by others, for instance, "I worry a fair amount about losing my partner." Cronbach alphas were .91 for Avoidance and .90 for Anxiety.

Working Alliance

The Working Alliance Inventory Short Form (WAI-S; Tracey & Kokotovic, 1989) was used to assess the working alliance between patient and therapist. The WAI-S is a 12-item self -report measure that assesses patient-therapist agreement on goals, tasks, and bond. Individuals rate items on a 7-point scale (1 = *never*; 7 = *always*). Internal consistency on both the therapist and participant scales are .87 and .93, respectively (Tracey & Kokotovic, 1989). The full inventory, the WAI (Horvath & Greenberg, 1986, 1989), is comprised of 36 items, with three subscales (12 items each). High reliability (Kivlighan & Shaughnessy, 2000) and relativity to treatment outcomes, client characteristics, and therapist technical activity have been found (see Constantino, Castonguay, & Schut, 2002; Kivlighan & Shaughnessy, 2000). Most recently, Busseri and Tyler (2003) have supported the interchangeability of the short and original forms for both the therapist and client versions and for the total and subscale scores. The present study used the patient version of the WAI-S and focused on the total score. The alpha coefficient was .91 for this sample.

Symptoms

Psychiatric symptoms were measured using the Symptom Checklist-90 Revised (SCL-90; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974), a 90-item checklist of items rated on a 5-point scale. The SCL-90 yields scores on nine dimensions, including anxiety, depression, hostility, somatic complaints, obsessive–compulsive symptoms, interpersonal sensitivity, phobic symptoms, paranoid ideation, and psychotic symptoms. The Global Severity Index is considered to be the best indicator of current level of disturbance on the SCL-90 (Lambert & Hill, 1994).

Procedure

Patients were invited to participate in clinic research by their therapists between the third and fifth therapy sessions. These early sessions were selected based on research that the working alliance is evident early on and requires time to develop (Gelso & Carter, 1985). In addition, the literature substantiates a positive and strong relationship between the early alliance (measured after third session) and patient outcomes assessed weeks or months later (Horvath & Greenberg, 1986; Horvath & Symonds, 1991; Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983).

Participating patients completed a packet of measures that included a brief demographic questionnaire, the SONI, ECRS, WAI-S, and SCL-90–R. All participants were informed that their responses were confidential and that their therapists would not have access to their responses.

Results

Preliminary Analyses

Prior to any analyses, tests of normality were used to determine what statistics, parametric versus nonparametric, would be necessary to explore the hypotheses. Given the small sample size, the Shapiro-Wilk test was used and the *p* values were nonsignificant indicating that the data come from a normal distribution and parametric statistics were appropriate. Table 1 includes the means, standard deviations, and intercorrelations for patient attachment style, working alliance, and SONI subscales at the third session of treatment.

Selfobject Needs and Symptoms

We expected to find a positive correlation between selfobject need orientations and level of symptoms early in treatment as measured by the SCL-90. We found two significant moderate correlations (Cohen, 1988). We found a positive moderate correlation between the need for mirroring (Factor 1) and self-reported symptoms. The more the patients revealed a desire for mirroring in relationships, the more they also reported symptoms when starting treatment. We found a negative moderate correlation between the avoidance of twinship and idealization (Factor 5) and self-reported symptoms. The more the patients reported **not** needing to feel connected to others or **not** needing to idealize others the less they reported having symptoms at the start of the treatment. We did not find significant correlations between the need for idealization (Factor 2) or the need for twinship (Factor 3) and symptoms.

Selfobject Needs and Attachment Dimensions

In addition, we predicted that avoidance of selfobject needs would positively correlate with attachment avoidance. The more patients denied selfobject needs of idealization/twinship (Factor 5) and mirroring (Factor 4), the more they would also deactivate their attachment needs. We found support for this hypothesis and a positive moderate corre-

Table 1
Correlations Between SONI Subscales, Attachment Dimensions, Therapy Alliance, and Symptom Report at the Third To Fifth Session of Psychotherapy

			Selfobject needs				
Measures	*M*	*SD*	Need Mirroring Factor 1	Need Idealizing Factor 2	Need Twinship Factor 3	Avoid Mirroring Factor 4	Avoid Id/Tw Factor5
Adult attachment dimensions							
Anxiety	4.40	1.11	.26*	−.02	.06	−.20	.08
Avoidance	3.39	1.25	−.04	.09	−.04	.00	.29**
Therapy relationship							
Total alliance	58.99	12.19	.11	−.02	.17	−.16	−.07
Bond	14.72	3.51	.16	−.06	.25*	−.20	−.16
Task	19.23	4.74	.12	−.01	.11	−.10	−.10
Goals	20.06	4.70	.04	−.00	.13	−.13	−.05
Patient symptoms	63.00	10.26	.27*	−.06	.09	−.15	−.28*

Note. $N = 83$; Id/Tw = Idealizing/Twinship; Symptoms = HCL-90 scores at third session of treatment.
* $p < .05$. ** $p < .01$.

lation between the avoidance of idealization and twinship (Factor 5) and attachment avoidance; however, we did not find a significant correlation between the avoidance of mirroring (Factor 4) and attachment avoidance. In essence, the greater the attachment avoidance the greater the avoidance of needing to be with similar or admiring others, but the level of attachment avoidance did not significantly corrrelate to avoiding the desire to be mirrored by others.

We also predicted that hunger for selfobject needs would positively correlate with attachment anxiety. Specifically, we expected that the more patients endorsed needs for closeness and dependency, or hyperactive attachment needs, the more they would reveal desires for mirroring (Factor 1), idealization (Factor 2), and twinship (Factor 3). The results revealed only a moderate positive correlation between attachment anxiety and the need for mirroring (Factor 1). The more the patient revealed attachment anxiety, the greater the desire for mirroring in relationships. There was no evidence of a relationship between attachment anxiety and idealization (Factor 2) or twinship (Factor 3).

Selfobject Needs, Attachment, and Symptoms

Prior to interpreting the hierarchical regression, we tested for multicollinearity using a direct investigation of the variance inflation factor (VIF). We found that the VIFs ranged from 1.00 to 2.02, which were well under the critical value of 10 (von Eye & Schuster, 1998). Therefore, the data did not present major multicollinearity problems and we interpreted the regression. The analysis partially supported our hypotheses. We did not find support for our hypothesis that selfobject needs would account for significant amount of variance, above and beyond attachment in the prediction of symptoms. In the hierarchical regression (see Table 2), we found that the two attachment dimensions accounted for 17% of the variance in HCL-90 scores ($R^2 = .167$, $p < .05$), with the block of selfobject needs not accounting for incremental variance. Within the full model, both anxiety and avoidance contributed significantly to symptoms. The more anxiety and avoidance, the greater the symptoms reported.

Table 2
Hierarchical Regression Analyses of Attachment Dimensions and Selfobject Needs in the Prediction of Symptoms at the Beginning of Therapy

		Symptoms		
	B	R^2	ΔR^2	*F*
Step 1		.167*		4.20
Attachment anxiety	.29*			
Attachment avoidance	.33*			
Step 2		.233	.067	1.61
Attachment anxiety	.22			
Attachment avoidance	.30			
Need for mirroring	−.20			
Need for idealization	.11			
Need for twinship	.15			
Avoidance mirroring	.11			
Avoidance idealization/twin	−.03			

Note. $N = 83$.
* $p < .05$. ** $p < .01$.

Selfobject Needs and Therapy Alliance

We expected to find a negative relationship between selfobject avoidance and patient rated working alliance at the third session. Specifically, we predicted that patients' avoidance of mirroring would negatively relate to the therapy alliance (Factor 4). We did not find a significant correlation between mirroring and the alliance. In addition, we expected that patients who minimized the need for idealizing/twinship (Factor 5) would report less therapy alliance early in the treatment. Again, we did not find a significant correlation between the avoidance of idealization/twinship and the alliance. Given the lack of significant correlations between selfobject needs and the overall alliance, we did not perform the hierarchical regression to determine the unique variance of selfobject needs in the prediction of the overall alliance.

Post Hoc Analyses

In order to gain a deeper understanding of the insignificant findings and, more importantly, to understand how selfobject needs may relate differently to the components of the alliance, we ran post hoc analyses and divided the total alliance score into the subscales: bond, task, and goals. We found one significant low to moderate correlation between the bond in therapy and the need for twinship (Cohen, 1988). The greater the need for twinship, the more the client perceived the bond in the therapy at the beginning of treatment. In essence, the more patients revealed a need to feel connected to others, the more they felt bonds between themselves and their therapists.

A post hoc hierarchical regression analysis was run to compare attachment dimensions to selfobject needs in the prediction of the therapy bond. The results (see Table 3), revealed that attachment anxiety and avoidance did not account for significant variance in bond ($R^2 = .01$; $p = .74$); however, the selfobject needs accounted for 28% of the variance in bond ($R^2 = .28$, $p < .01$). Need for twinship, avoidance of mirroring, and avoidance of idealization accounted for significant variance in therapy bond. The more need for twinship and the less avoidance of mirroring and idealization, the more the bond.

Table 3
Hierarchical Regression Analyses of Attachment Dimensions and Selfobject Needs in the Prediction of Therapy Bond

		Bond		
	B	R^2	ΔR^2	*F*
Step 1		.011		.73
Attachment anxiety	.06			
Attachment avoidance	.07			
Step 2		.283**	.272	3.87
Attachment anxiety	.13			
Attachment avoidance	.26			
Need for mirroring	−.27			
Need for idealization	.06			
Need for twinship	.40**			
Avoidance mirroring	−.37*			
Avoidance idealization/twin	.40**			

Note. $N = 83$.
* $p < .05$. ** $p < .01$.

Discussion

The current study is the first to apply the SONI to psychotherapy patients, and the first to explore how selfobject needs relate to patient attachment styles, symptoms, and perceptions of the psychotherapy relationship. The findings support some of the hypotheses, but not all, and they suggest the need for future psychotherapy research using the SONI with patients in treatment.

Selfobject Needs and Patient Symptoms

In line with one of our hypotheses and researcher's prior findings (Banai et al., 2005), we found that hunger for mirroring increased with patient reported symptoms early in treatment. Because the findings are based on correlations, we do not know for certain if feeling worse leads to increased desire for mirroring, or if people who hunger for mirroring tend to be more symptomatic. It is possible that the more symptoms one presents with, the more one hungers for mirroring as a way of coping with increasing distress.

Banai et al. (2005) found that hunger for mirroring was significantly related to the dimension of adult attachment anxiety. Adults with more attachment anxiety tend to express more symptoms to engage others in what has been described as hyperactivating strategies. These strategies are unconscious efforts to garner the other's attention and reinforce the interaction in which one feels cared for. Fosha (2000) describes anxiously attached adults as having the capacity to feel but not deal with their emotions. They seek out the reassurance from others and this bolsters their sense of self-esteem. This is similar to Kohut's notion that mirror hungry individuals lack a true sense of self and are often maintaining their sense of self-esteem by seeking admiration from others.

As hypothesized, the more patients denied needing others, the need to feel connected to them or to idealize them, the less symptoms they reported. According to Fraley and Shaver (2000), the avoidance of selfobject needs may be a defensive reaction, similar to dismissive attachment styles. If this is the case, it is likely that patients who avoid selfobject needs are less aware of their internal states, emotional needs, or longings (Schore, 2002). On a conscious level, they may say to themselves, "I'm doing fine on my own . . . I do not have any of these symptoms and I do not need therapy." Recognizing the defensive nature of such a response may cue the therapist to respond in ways that both empathize with the patient's preference for self-sufficiency and disavowed longings for attachment (Lachmann, 2008).

Selfobject Needs and Patient Attachment Styles

We partially replicated Banai et al. (2005) findings linking selfobject needs and adult romantic attachment. We identified a moderate correlation between the avoidance of idealization/twinship and attachment avoidance, but we did not find a significant correlation between avoidance of mirroring and attachment avoidance. In other words, denying needs to be belong (denying twinship) or denying desire to admire someone superior (denying idealizing) was related to avoidant adult romantic attachment and avoidance of mirroring (denying the need to be admired) was not. Lopez et al. (2013) found the same findings as we did with a nonclinical sample, and this may make sense if we look more closely at the nature of twinship, idealizing, and mirroring. Blatt (1990) describes the patient who is more introjective and similar to the more avoidant patient. Individuals on this end of the spectrum tend to value self-definition over relationships. They are more concerned with maintaining self-esteem (gaining the mirroring from others), and there-

fore, they are more inclined to reject the need to admire another (indicating weakness and dependency) or be close to a peer (indicating dependency).

We would argue that these more avoidant patients tend to value mirroring because mirroring is consistent with their goal of maintaining self-esteem. There is no need to be defensive about mirroring because it does not challenge their desire for self-sufficiency or their sense of independence. Denying or accepting the statement "I enjoy when people admire me" (need for mirroring) is acceptable to an individual with more attachment avoidance. On the other hand, "I am attracted to successful people," (need for idealizing) is an indication of admiring another, and it could be threatening to a dismissing patient who envies or competes with successful peers or values self-sufficiency (Bartholomew & Horowitz, 1991). A more avoidant patient might also be activated by the statement, "I feel stronger when I have people around who are dealing with similar problems," an indication of twinship, because this could trigger dependency needs, underlying shame, and perceived weakness. As a matter of fact, group therapy researchers have found that more avoidant members are activated in groups and struggle to cope with the pressure to belong in the group. Unlike more anxious and secure group members, they tend to have decreasing alliances over time and are more likely to drop out of group treatment (Tasca et al., 2006). They are less likely to be aware of their own internal states given their deactivating strategies and this decreases the likelihood that they are aware of their selfobject longings. More avoidant people, in nonclinical samples, tend to minimize their needs, avoid vulnerable feelings, and focus on their own personal strengths (Mikulincer & Shaver, 2007).

Similar to the more avoidant patients, we observed a positive correlation between need for mirroring and attachment anxiety but not needs for idealizing or twinship. Intuitively, it makes sense that increased attachment anxiety about rejection and abandonment would correlate with increased longing for approval and validation. Individuals with more attachment anxiety tend to engage in hyperactivating strategies such as seeking out reassuring feedback from others about their worth and desirability.

However, we were surprised that there was no positive correlation between attachment anxiety and needs for idealizing because more anxious individuals tend to overvalue others while devaluing themselves (Bartholomew & Horowitz, 1991). Perhaps despite the increased efforts of anxiously attached individuals to maintain relationships and the sense of safety from abandonment, they may learn to modulate their expression of idealization of others so as not to overwhelm or alienate them. Researchers have also shown that more anxious adults, similar to anxious infants, often feel conflicted about attachment figures alternating between anger and submissiveness in relationships (Mikulincer & Shaver, 2007). The alternating feelings of disappointment and dependence may inhibit a direct correlation with the need for idealization. Another possibility is that need for idealization may not be as pathological as Kohut (1971) suggested. Banai et al. (2005) found that the hunger for idealization was not related to self-esteem, narcissistic personality, self-cohesiveness, or affect regulation. They speculate that Kohut may have been incorrect, and it is possible that hunger for idealizing others in adulthood may not be representative of pathology and may be an adaptive strategy.

Selfobject Needs, Attachment, and Symptoms

When comparing the amount of variance both attachment and selfobject needs contribute to symptoms, we found that only attachment anxiety and avoidance contributed significantly. Prior studies have documented the relationship between attachment and symptoms

(see Mikulincer & Shaver, 2007 for review); however, we had expected that selfobject needs would also contribute to symptoms above and beyond attachment. It is possible that when attachment is taken into account, selfobject needs no longer relate to symptoms. Banai et al. (2005) found that the associations between selfobject needs and emotional distress were mediated by low self-esteem. Specifically, they found that unmet selfobject needs for mirroring and idealizing led to low self-esteem and it was the low self-esteem that related to depression and anxiety. Future studies that explore if attachment styles mediate the relationship between selfobject needs and symptoms are needed.

Selfobject Needs and Therapy Alliance

We hypothesized that selfobject needs would be significantly related to patient ratings of the therapy relationship. Contrary to our hypotheses, we did not find a significant correlation between the therapy alliance and selfobject needs or denial of those needs. In order to understand these findings, we looked more closely at the subscales that comprise the therapy alliance (task, bond, and goals), and we found one significant negative correlation between the bond in therapy and the need for twinship. We found that the *greater* patients acknowledged a need for twinship, the *more* they rated the bond with the therapist. The greater their hunger for such connection with a similar other, the more they may be satisfied with what they received in the early therapy relationship. Interestingly, we did not find any significant relationship between selfobject needs and task or goal of therapy. In essence, selfobject transferences were most related to the bond, feeling of connection to the therapist, not as much with the work of the therapy.

Selfobject Needs, Attachment, and Bond

Although we did not have predictions with regards to how selfobject needs would relate to bond alone, post hoc hierarchical regression analyses revealed that selfobject needs better predict of the therapy bond compared to adult romantic attachment dimensions. Interestingly, it may be that selfobject needs directly relate to how a client will perceive liking the therapist and feeling safe in the relationship. Need for twinship, avoidance of mirroring, and avoidance of idealization accounted for significant variance in therapy bond. The more need for twinship and the less avoidance of mirroring and idealization, the more the bond. It is as if patients who come to therapy seeking to belong, not actively avoiding the need to be praised, and being open to admiring another are better able to attach to the therapist.

Limitations

Despite the interesting findings, there are several limitations worth noting. First, this study utilized a homogenous sample and relied on correlational analysis. Using only a single-time-point correlational design prevents us from recognizing the direction of relationships or causality. Replicating these findings with a larger sample size and a patient population more diverse in ethnicity, age, and severity of symptomatology would allow us to generalize our findings to other populations and other forms of treatment that are less relational in nature. We focused on a healthier outpatient population and it would be interesting to assess selfobject needs in patients with more serious psychopathology in an inpatient setting. In addition to using more diverse patients, it is important to use different methodologies that allow us to look at changes in selfobject needs as they relate to different types of therapy interventions.

Second, self-report measures are limited and we are only able to assess what a patient is aware of. We are not able to assess their unconscious processes and whether they may have under- or overrepresented their attachment, selfobject needs, symptoms, or their perceptions of the therapy relationship. This is a limitation to many studies that desire to assess constructs that involve unconscious processes or aspects of the self that are out of awareness. Future research may ask the therapist or supervisor to complete the SONI to assess selfobject needs from different perspectives. It may also be beneficial for future researchers to use attachment measures that tap into unconscious processes such as the Adult Attachment Interview. This is especially important when identifying individuals with more avoidant attachments who lack awareness of their internal states. In addition to the limitations of the ECR-S, it is important to address the limitations of the SONI and how the measure emphasizes the independence of selfobject needs (assessed in separate subscales) as opposed to the overlapping nature of selfobject needs that relate to one another. This influences our findings because we focus on these needs separately in our analyses and may miss the complexity of how selfobject needs influence one another and the therapy relationship.

Third, the time in which these measures were completed influences the findings. For instance, the therapy alliance may be perceived differently at different points in treatment and we focused on the third to fifth session of therapy. The early therapy relationship is replete with myriad variables including the interpersonal dynamics between the therapist and patient that could influence the perceptions of selfobject needs. In the future, it would be important to assess selfobject needs before treatment even begins, so as to minimize the impact of curative factors involved even at the level of first intake or session. In addition, it would be important to assess the alliance at later intervals over time to explore how selfobject needs relate to the development of the alliance in treatment.

Implications for Future Research

Future research is needed to understand the complexity of selfobject needs and how they may influence psychotherapy process and outcome. Identifying patients who may be challenging to engage in therapy, such as patients with more avoidance of selfobject needs, may help the therapist establish a specific approach to building and maintaining the working alliance (Lachmann, 2008).

Researchers might examine various therapy interventions and how they differentially facilitate or hinder the therapy relationship for patients with different selfobject needs. Blatt (1992) compared patients with different personality configurations in different types of treatment and found that certain types of patients benefit more from certain types of treatments. It is possible that certain types of therapy interventions address certain selfobject needs better than others. Because an individual's success in seeking and obtaining selfobject fulfillment in relationships hinges on his or her ability to express these needs clearly with responsive and affectively attuned others, therapists might help such patients develop a greater awareness of these needs and how they influence their relationships.

Researchers could also work to illuminate how therapists' countertransference influences these selfobject needs. To what degree does the therapist's attachment and selfobject need orientation interact with the patient's? Marmarosh et al. (in press) found that therapists with more attachment anxiety have better early alliance with less anxious patients. It is possible that therapists' selfobject needs interact with clients' selfobject needs. The therapist who seeks out mirroring works best with a patient who needs less

mirroring. In essence, there may be a complimentarity of selfobject longings that facilitate the therapy relationship, similar to complimentary attachments facilitating treatment (Tyrrell, Dozier, Teague, & Fallot, 1999). The field is wide open for studies investigating selfobject needs in treatment.

Clinical Implications

Wallin (2007) describes how therapists can work with patients who have different relationship histories and internal representations of self and others. For example, he describes how patients with more attachment avoidance may struggle with identifying and expressing vulnerable emotions in sessions. They tend to emphasize self-sufficiency and are at risk of dropping out of treatment when dependency needs are overwhelming.

Therapists who identify selfobject needs may be able to do the same. Identifying patients who endorse avoidance of idealization and twinship may help therapists be more attuned to the patient's underlying dynamics that influences the alliance. The identification of patients who express intense hunger for mirroring will help therapists understand the sensitivity of the patient to rejection and narcissistic injury. This may help the therapist pay careful attention to ruptures in the sessions and to facilitate repairs (Safran, Muran, Samstag, & Stevens, 2001).

There is a growing literature emphasizing the importance of rupture and repair in psychotherapy (Safran, Muran, & Eubanks-Carter, 2011). Despite this growing literature, there has been little attention given to how repairing ruptures is something Kohut (1971) discussed when he described the process of transmuting internalization. Kohut emphasized the importance of optimal responsiveness and the importance of repairing breaks in empathic attunement. Future research could explore how the process of repairing ruptures in psychotherapy fosters changes in selfobject needs over time.

More importantly, this study demonstrates the usefulness of the SONI and hopefully encourages clinicians to use this measure so they can use to begin to empirically study the effectiveness of long-term psychodynamic treatment interventions. We now have a measure that will allow us to garner more empirical research and test Kohut's (1984) theory.

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