

Concept and Percept Formation in Object Relations Theory

J. Reid Meloy, Ph.D.
La Jolla, CA

A theoretical model is presented which differentiates between concept and percept formation in object relations theory. The model is composed of ten "units of experience" that are derived from the psychological variables of identity, space, and time. Its construct validity in relation to current psychoanalytic theory is discussed.

The aim of this paper is to introduce a theoretical model that distinguishes between concept and percept formation in object relations theory. The differentiation between concept and percept formation has not been emphasized in the writings of the major object relations theorists in the United States during the past decade (Kohut, 1971; Kernberg, 1975; Masterson, 1981); and prior to this time a relatively small body of psychoanalytic literature was devoted to an understanding of the role of percept formation in relation to the self (Lewis, 1968; Spiegel, 1959), to hallucinations (Fischer, 1969), space (Schilder, 1935), thought (Guttman & Sloane, 1962), regression (Leovici, 1960; Lewis, 1968; Sperling, 1959; Szalita, 1958), and, of course, as a developmental precursor of self-object differentiation in the work of Mahler (1968, 1975).

I will assert the central role of percept formation in delineating an internally consistent and externally valid object relations theory. Before proceeding, however, it is important to note that any distinction between concept and percept formation, however critical as an explanatory model for the purpose of this paper, is empirically an arbitrarily dichotomous division. The perception-conception formative process is psychologically, phenomenologically, and probably neurophysiologically, a continuous variable that is obviously disparate only at its extremes. Rapaport noted this in the "cogwheeling

effect” of the perceptual-associative process that was apparent in Rorschach responses (Rapaport, Gill, & Schafer, 1976, p. 274). Perception, the vehicle of human experience, cannot be empirically removed from associations, the nails that hold any conceptual framework together. Yet, for purposes of theoretical clarity, the separation of percept and concept formation into two dichotomous variables is justified as a parsimonious solution to several knotty problems in current object relations theory.

Hinsie and Campbell (1974) defined perception as the act or process of representing reality as it appeared to the senses rather than the intellect. It is a primary, immediate, subjective, and bimodal activity that organizes interoceptive and exteroceptive sensory-neural impulses and the contact-linking barrier that distinguishes the two. Percept formation developmentally and phenomenologically precedes concept formation. Grotstein (1980) emphasized the primary role of the perceptual background in his construct, the Background Object of Primary Identification: The mother provides the perceptual background as a primary object of identification for the infant prior to any conceptual knowledge of the “mother” by the infant or any idea of separateness from the mother. Percept formation provides for the infant a beginning, subjective sense of “I.” The concept of self, thrust to the interpersonal foreground by the verbally assertive toddler, represents the birth of a conception that becomes limited and defined as a foreground experience. The conceptual sense of self is the foreground dependent upon the primary background perceptual experience of a sense of “I”; which, in turn, is the perceptual heir to the Background Object of Primary Identification, the mother.

Concept formation is the process that objectifies experience. It may have perceptual properties, but these are not necessary. It is an active process that is central to the ego functions of memory, symbolization, judgment, abstraction, comprehension, and insight. In the context of object relations theory concept formation objectifies and limits the perception of self and other. It is not a bimodal experience; it is a modal “frame of reference” for the self and object that has both form and value (Spiegel, 1959). Concept formation is free to be wedded to percept formation at a concrete level of thought or imagery; or it can be divorced from perceptual experience at an abstract or symbolic level of thought. It may be the quintessential marker of secondary process thought; or it may be grossly distorted or imaginatively designed into a form and content reflecting the unconscious interplay of the primary process mechanisms of displacement and condensation (Meloy, 1984). The distinguishing criterion between concept and percept formation is the capacity of the former to proceed without sensory-perceptual data. Because of this capacity for autonomous functioning, concept formation represents developmentally a higher, yet secondary, level of cortical functioning. Perception, attention, sensory-motor integration, and skin-boundary cohesion are biological-perceptual factors that precede the formation of self and ob-

ject concepts (Grotstein, 1980; Mahler, 1958; Ornitz, 1969, 1970; Ornitz & Ritvo, 1968a, 1968b).

The distinction between concept and percept formation can also be understood through Bion's grid of elements of psychoanalysis (1977). The vertical axis, representing an increasing degree of complexity acquired by thought, differentiates the percept and concept between Row E and F. Row E is a conception that has a sense and perceptual predominance (Row A through E would correspond to my use of the term *percept formation*); whereas Row F is a concept that derives from a conception by a process of abstraction which is freed from sensory-perceptual elements (thus, my use of the term *concept formation* refers to Rows F through H) (Grinberg, Sor, & de Bianchedi, 1977).

THE MODEL

Models provide operative ways of solving problems that patients present. This model provides a link among several clinical problems in psychoanalytic understanding and the main body of object relations theory. It is not to be mistaken for a new theory, and hopefully will restore a sense of the concrete and personal to a body of knowledge that oftentimes leaves the student of object relations theory in a dry intellectual labyrinth with no hope of clinically grounding, empirically measuring, or phenomenally experiencing such a thing as an "object." A model should deductively promote clinical understanding, and clinical observations should inductively refine a model.

The model in Fig. 1 hypothesizes three independent variables that are quite useful for psychodiagnostic, psychoanalytic, and research purposes. The three variables are continuous, but for reasons of analysis and parsimony are made dichotomous.

1. Identity—this variable is dichotomized into "object relations" and "self-relations" and refers to the subjective experience of "I" and "not-I." (Immediately I have fallen prey to conceptual limits and definitions to convey a primarily perceptual experience, but verbal and written communication demands it. It is ironic that to convey the perceptual distinction, one must conceptually limit it.)

2. Space—this variable is dichotomized into concept and percept formation. The spatial dimension can be understood from several perspectives: phenomenally it is the experience of objective conceptual space within the mind as opposed to the subjective experience of perceptual spatial reality as a being-in-the-world (Grotstein, 1978; Heikki & Hagglund, 1980; Meloy, 1984). Psychologically it is the evaluating-abstracting-ordering ability of the mind as opposed to the perceptual-sensory experiences of the mind. (It is the

OBJECT RELATIONS			SELF RELATIONS		
PERCEPT FORMATION		CONCEPT FORMATION	CONCEPT FORMATION	PERCEPT FORMATION	
INTROV.	EXTRAV.			EXTRAV.	INTROV.
PAST I	II			IV	VI
	PRESENT III	V	VII	IX	

FIG. 1 A model of concept and percept formation in object relations theory.

congruency or incongruency of this dichotomy that is measured in the Rorschach process, and has often been empirically defined as formal thought disorder.) Physiologically, the conceptual spatial dimension is found in the secondary associational cortical areas in both the right and left hemispheres as opposed to the perceptual-sensory spatial dimension found in the primary associational cortex and the vestibular-cerebellar pathways that both relay and discriminate interoceptive and exteroceptive stimuli (Frick, 1982). As will be noted in Fig. 1, the perceptual spatial dimension has also been dichotomized further into introverted and extraverted. This distinction is my attempt to imply a psychological direction to these subjective experiences of the patient. The introverted sphere indicates a more autistic, isolated activity, yet it is still bound to both internal and external sensory-perceptual data. The extraverted sphere, although it also involves both interoceptive and exteroceptive stimuli, indicates a more involved, active, outward relationship with one's physical body and its contact with the world.

3. Time—this continuous variable is dichotomized into past and present, again for reasons of clinical analysis and empirical observation. As one will notice, the introverted self and object percepts are not dichotomized on this dimension. This is to pay homage to the phenomenal experience of dreams, daydreams, and visual and symbolic images that by their very nature transcend the dictates of time and are often experienced as timeless.

The model yields ten "units of experience." To facilitate understanding of the model, each unit will be numbered and defined.

Object Relations

I. The introverted object percept. This experience unit encompasses the “not-I” represented in dreams, daydreams, purposeful visualizing, sexual and aggressive fantasies, and intentional and spontaneous visual images or auditory sounds “heard” in the mind. The common denominator is that the experience unit is identified with a sensory mode, usually vision or audition. Although phenomenally experienced as coming from within the self (introverted), it is identified as not belonging to the self, hence, an object. It is experienced as occurring in the present.

II. The extraverted object percept, past. This experience unit is also bound to a sensory mode, yet emerges in clinical data through the memories of the physical appearance and behavior of others from the patient’s past history. Most notably these “not-I” objects would be memories of family members, peers, siblings, parents, teachers, mentors, and so forth. The patient’s memories of other’s physical bodies, their movement, sounds, smells, tactile sensations, and perhaps the observations of certain empathic, aggressive, or sexual behavior; for example, the recall of the mother’s vagina for the first time and remembering how dense and dark the pubic area appeared to the patient as a 4-year-old boy would represent a vivid part object percept, past (although the value implicit in “how dense and dark” would imply some conceptual elaboration).

III. The extraverted object percept, present. This experience unit is simply exteroceptive sensory data that is organized into a meaningful percept. It would be clinically apparent in the visual, auditory, and somesthetic experience of others outside the skin boundary and the experience of “I.” The Rorschach form level is the most direct psychodiagnostic measure of this experience unit.

IV. The object concept, past. This experience unit is not necessarily bound to perceptual-sensory data from the present or the past. It is clinically apparent in the memories of other’s judgments, values, beliefs, and the meanings attached to the behavior that resulted in the extraverted object percept, past. It is linked to the latter unit of experience, but is free to conceive of the way in which experience was ordered, abstracted, categorized, classified, and valued by others in the patient’s past.

V. The object concept, present. This unit of experience, like the other concept formations, is composed of both form and content. The form is the cognitive schemata that the patient uses to classify and order

perceptual-sensory experience, both the introverted and extraverted object percepts. It is also measurable in the present as the patient's capacity for concept formation and abstraction. The contents of the object concepts are the attributions, values, judgments, meanings, and so forth that are attached to the sensory-perceptual experience of the "not-I" in the model, units I-III.

Self-Relations

VI. The self-concept, past. This experience unit is not always bound to sensory-perceptual data from the present or the past. It is clinically apparent in the memories of one's own judgments, values, beliefs, and attitudes toward behaviors that were remembered in the extraverted self-percept, past. It is linked to the latter unit of experience but is free to conceive of the way in which self-experience was ordered, abstracted, classified, and judged.

VII. The self-concept, present. Again the form of this experience unit is the cognitive schemata the patient uses to classify and order sensory-perceptual experience, both introverted and extraverted self-percepts. It is also measurable as the patient's capacity to conceptualize the experience of oneself through metaphor, symbol, and most importantly, insight. The contents of the self-concept, present, are the attributions and judgments attached to the sensory-perceptual experience of the "I" in this model, units VIII-X.

VIII. The extraverted self-percept, past. This experience unit is also bound to the sensory mode. It is apparent in the memories of one's physical appearance and behavior as a child or an adult, felt movement or orientation in space, physical growth and development, exploration of erogenous zones, and one's memories of emotional reactions in relation to others. The long-term memory storage of self-perceptual-sensory experience includes both interoceptive and exteroceptive neural impulses. The child exploring his genitals, for example, experiences the visual stimulus of viewing his genitals, the tactile stimulus of feeling his genitals at the skin boundary of his fingers, and, of course, the pleasurable interoceptive emotional and sexual responses that are triggered by the manipulation. All of this essentially bimodal (inside and outside) sensory-perceptual data is contained in the extraverted self-percept, past.

IX. The extraverted self-percept, present. This experience unit is composed of sensory-perceptual data of a visual, auditory, kinesthetic, vestibular, olfactory, or somesthetic nature that arise within the skin boundary in the context of activity in the environment. It could partially be inferred by the self-care and physical appearance of the patient. The anorexic adoles-

cent, for example, illustrates the gross distortion of both the self-concept and percept as an internal representation: the patient appears overweight to herself in the mirror, although any reasonable observer would attest to her severe undernourished state. This projected self-percept distorts the patient's capacity to actually "see" her physical condition; while the self-concept attributes meaning and motivation to the self-percept; for instance, "I'm not thin enough." Successful treatment would split the self-percept and concept and thus dilute the power of the conceptual attribution.

X. The introverted self-percept. This experience unit is the "I" represented in dreams, daydreams, purposeful visualizing, sexual and aggressive fantasies, intentional or spontaneous visual images, or auditory sounds "heard" in the mind and embraced as a part of "I." It is phenomenally located as coming from within the self and is identified as belonging to the self.

THE VALIDITY OF THE MODEL

How useful is a model that emphasizes the distinction between percept and concept formation in object relations theory? Three applications of the model suggest that it is a valid and parsimonious addition to object relations theory.

Construct Validity

The experience units defined in the model are supported by the equilibration theory of Piaget (1954). The construction of reality involves both the assimilation of sensory-perceptual data into already existing self- and object concepts, and the accommodation of newly integrated experience through alteration of self- and object percepts. The units of experience in this model also correspond to a sequential theory of information processing, which generally posits that icon-encoding processes (the percept units of experience in the model) precede the assembling-schemata processes (the concept units of experience in the model).

The Distinction Between Paranoia and Schizophrenia

Magaro postulates an integration theory of schizophrenia and paranoia (1981) based upon a wealth of empirical evidence that suggests that paranoia should be considered a separate diagnosis from schizophrenia.

Integration theory is a theoretical framework which accounts for the findings of symptomatic, clinical, experimental, and neurological differences in para-

noid and schizophrenic processes. This approach explains schizophrenic performance as an inability to integrate perceptual and conceptual processes in a normal manner. The basic postulates are that paranoids rely on conceptual processes without adequate constraint by perceptual data, and that schizophrenics rely primarily on perceptual data without adequate categorization and classification from conceptual processes. (Magaro, 1981, p. 653)

My model provides a framework that allows these two postulates to be understood in an object relations context, and also lends support to the notion that a distinction between concept and percept self- and object representations is a parsimonious construct to crystallize several findings in empirical research concerning paranoia and schizophrenia: paranoids use a controlled processing strategy while nonparanoids use an automatic-processing strategy in encoding information; that is, processing or transmitting information bits into long-term memory storage (Schneider & Schiffrin, 1977); a deficit in the recall memory of schizophrenics but not paranoids has been repeatedly demonstrated (Bauman & Kolisnyk, 1976; Koh & Kayton, 1974; Koh, Kayton, & Berry, 1973); schizophrenics do not use normative categorical clustering schemes to the same extent as normals, nor do they use as much subjective organization to facilitate recall (Koh et al., 1973); and finally, there is evidence for a left-hemisphere deficit in schizophrenia (Flor-Henry, 1976).

My model suggests that paranoids will have more rigidly defined, valued, and categorized self- and object concepts that may be unalterable in the face of continual interoceptive and exteroceptive stimuli that give form to the self- and object percepts. Moreover, the schizophrenic would manifest a deficit in self- and object concept formation that would magnify a dependency on self- and object percept formation: a futile attempt to accommodate, in Piaget's sense, to all sensory-perceptual stimuli.

THE PROBLEM OF EGO AUTONOMY AND SELF- OBJECT FUSION IN THE NARCISSISTIC PERSONALITY DISORDER

Major theorists within the psychoanalytic object relations tradition during the past decade have been confounded by the correspondence of ego autonomy and self-object fusion in the narcissistic personality disorder (Kohut, 1971; Kernberg, 1975; Masterson, 1981). How can object relations theory explain the coexistence of self-object fusion and mature ego functioning in the narcissistically disordered adult, particularly when self-object fusion has theoretically been understood as impeding autonomous ego functioning? Self-object fusion in the narcissist is clinically apparent as a grossly distorted, grandiose sense of self and an incapacity to feel empathy toward others. At

the same time the narcissistically disordered individual demonstrates autonomous ego functioning through various learning, memorizing, judging, problem-solving, decision-making, and other adequate reality-testing behaviors.

By emphasizing both the perceptual and conceptual nature of self- and object relations, a solution to the self-object fusion and ego autonomy problem in the narcissistic personality disorder is suggested.

Reality testing is the sine qua non of a complex ego activity (Abend, 1982). A fundamental measure of reality testing is the capacity to distinguish between interoceptive and exteroceptive stimuli, a sensory-perceptual task. Narcissistically disordered adults invariably provide good form level responses on the Rorschach, and often may exhibit an exquisite if amoral sense of reality testing in perceiving the motives and needs of others. The distinction between percept and concept formation offers the hypothesis that self- and object *percept* differentiation in the narcissistically disordered individual is normal. How then does one explain the fusion of self- and object representations in the narcissist? *Precisely because the fusion occurs between self- and object concepts and remains divorced from the developing and separate self- and object percepts.* The distinction between the subjective and primarily background sense of "I" and "not-I" is perceptually clear. The manner in which the self and its relation to others is conceived, however, is distorted and exaggerated, reflecting the fusion of self- and object concepts. The conceptual other becomes a psychological extension of the conceptual self.

The fused self-object concept remains an insular, autonomous psychic process that becomes clinically evident in fantasies of achievement, power, admiration, perfection, and entitlement. As one 40-year-old male patient stated in the face of personal bankruptcy, "I don't aspire to greatness; I claim it."

Achievement for the narcissistic personality disorder can proceed relatively unhampered since the differentiated self- and object percepts support ego skills that are socially and financially rewarded in the nonintimacy of the workplace: decisive and autonomous judgments, emotional detachment, objectivity, high self-regard, and pragmatism.

The fused self-object concept only becomes problematic when issues of intimacy disrupt the life of the narcissist. Suddenly, good reality testing, that is, self- and object percept differentiation, is not enough. Sustained intimacy requires empathy, an acknowledgment of worth of the other, and a realistic appraisal of one's self-concept in relation to others in the world. The fused self-object concept of the narcissist, which has heretofore remained submerged as an exaggerated, yet inherently supportive, self-representation, now intrudes into intimate relationships as an "I" that is entitled, angry, and grandiose. The fused self-object concept necessitates that others remain without separate worth and empathic regard. The presence of value in others

must be denied or enveloped to be, again in Piaget's sense, assimilated by the fused self-object concept of the narcissist.

SUMMARY

I have presented a theoretical model which differentiates between concept and percept formation in object relations theory. The model is composed of ten "units of experience" that are derived from three theoretically dichotomous variables: identity (self and other), space (concept and percept), and time (past and present). Its usefulness is discussed by (a) illustrating the model's correspondence with Piaget's equilibration theory and general information-processing sequences, (b) providing support for Magaro's distinction between paranoia and schizophrenia, and (c) offering a parsimonious answer to the psychoanalytic problem of ego autonomy and self-object fusion in the narcissistic disorders.

REFERENCES

- Abend, S. (1982). Some observations on reality testing as a clinical concept. *Psychoanalytic Quarterly*, *51*, 218-238.
- Bauman, E., & Kolisnyk, E. (1976). Interference effects in schizophrenic short-term memory. *Journal of Abnormal Psychology*, *85*, 303-308.
- Bion, W. (1977). *Seven servants*. New York: Jason Aronson.
- Fischer, R. (1969). The perception-hallucination continuum. *Diseases of the Nervous System*, *30*(3), 161-171.
- Flor-Henry, P. (1976). Lateralized temporal-limbic dysfunction and psychopathology. *Annals of the New York Academy of Sciences*, *280*, 777-795.
- Frick, R. (1982). The Ego and the vestibulocerebellar system: Some theoretical perspectives. *Psychoanalytic Quarterly*, *51*, 93-122.
- Grinberg, L., Sor, D., & de Bianchedi, E. (1977). *Introduction to the work of Bion*. New York: Aronson.
- Grotstein, J. (1978). Inner space: Its dimensions and coordinates. *International Journal of Psychoanalysis*, *59*, 55-61.
- Grotstein, J. (1980). A proposed revision of the psychoanalytic concept of primitive mental states. *Contemporary Psychoanalysis*, *16*(4), 479-546.
- Guttman, S., & Sloane, P. (1962). Perception and its relation to thought. *Bulletin of the Philadelphia Psychoanalytic Association*, *12*, 91-93.
- Heikki, P., & Hagglund, T. (1980). Inner space of the body image. *Psychoanalytic Quarterly*, *49*(2), 256-283.
- Hinsie, L., & Campbell, R. (1974). *Psychiatric dictionary* (4th ed.). New York: Oxford University Press.
- Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. New York: Science House.
- Koh, S., Kayton, L., & Berry, R. (1973). Mnemonic organization in young nonpsychotic schizophrenics. *Journal of Abnormal Psychology*, *81*, 299-310.

- Koh, S., & Kayton, L. (1974). Memorization of "unrelated" word strings by young nonpsychotic schizophrenics. *Journal of Abnormal Psychology, 83*, 14-22.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Leovici, S. (1960). Symposium on psychotic object relations. *International Journal of Psychoanalysis, 41*, 540-558.
- Lewis, A. (1968). Perception of self in borderline states. *American Journal of Psychiatry, 124*(111), 1491-1498.
- Magaro, P. (1981). The paranoid and the schizophrenic: The case for distinctive cognitive style. *Schizophrenia Bulletin, 7*(4), 632-661.
- Mahler, M. (1958). Autism and symbiosis, two extreme disturbances of identity. *International Journal of Psychoanalysis, 39*(2-4), 77-83.
- Mahler, M. (1968). *On human symbiosis and the vicissitudes of individuation*. New York: International Universities Press.
- Mahler, M. (1975). *The psychological birth of the human infant*. New York: Basic Books.
- Masterson, J. (1981). *The narcissistic and borderline disorders: An integrated developmental approach*. New York: Brunner Mazel.
- Meloy, R. (1984). Thought organization and primary process in the parents of schizophrenics. *British Journal of Medical Psychology, 57*, 279-281.
- Ornitz, E., & Ritvo, E. (1968a). Neurophysiologic mechanisms underlying perceptual inconstancy in autistic and schizophrenic children. *Archives of General Psychiatry, 19*(1), 22-27.
- Ornitz, E., & Ritvo, E. (1968b). Perceptual inconstancy in early infantile autism. *Archives of General Psychiatry, 18*(1), 76-98.
- Ornitz, E. (1969). Disorders of perception common to early infantile autism and schizophrenia. *Comprehensive Psychiatry, 10*(4), 259-274.
- Ornitz, E. (1970). Vestibular dysfunction in schizophrenia and childhood autism. *Comprehensive Psychiatry, 11*(2), 159-173.
- Piaget, J. (1954). *The construction of reality in the child*. (M. Cook, Trans.). New York: Basic Books.
- Rapaport, D., Gill, M., & Schafer, R. (1976). *Diagnostic psychological testing*. New York: International Universities Press.
- Schilder, P. (1935). Space, time, and perception. *International Journal of Psychoanalysis, 16*(3), 366.
- Schneider, W., & Schiffrin, R. (1977). Controlled and automatic human information processing: I. Detection, search, and attention. *Psychological Review, 84*, 1-66.
- Sperling, M. (1959). Some regressive phenomena involving the perceptual sphere. *International Journal of Psychoanalysis, 40*, 304-307.
- Spiegel, L. (1959). Self, sense of self, and perception. *Psychoanalytic Study of the Child, 14*, 81-109.
- Szalita, A. (1958). Regression and perception in psychotic states. *Psychiatry, 21*, 53-63.