The Role of Attachment Functions in Psychotherapy

Jeremy Spiegel, M.D.
Sally K. Severino, M.D.
Nancy K. Morrison, M.D.

The authors propose to clarify concepts of emotional attunement and failures of attunement in early development derived from theoretical and clinical work (Kohut) and infant psychiatry (Stern). Early attunement failures are experienced as shameful by the infant/child, and without repair they form a nidus for later destructive adult interpersonal relationships, "social blindness," and depression. The authors present a case illustrating these ideas. The role of empathic attunement experienced in the unique setting/structure of psychotherapy emerges as the single critical variable for a successful outcome.

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Concerns with sympathy and compassion are age-old factors in medicine and healing. They constitute the matrix from which our twentieth-century focus on empathy emerged.[1] Interests in healing within relationship and in the role of empathy bridge two lines of development: the clinical material on development of self and the findings from maternal-infant research. With regard to the first, Melanie Klein[2] viewed early infant development as a process moving from attachment to separation of the self. Heinz Kohut[3] emphasized the role of empathy in the development and formation of the self, underscoring his belief that the goal of human maturation involves differentiation within empathic relationship. With regard to the second, infant research has extended these understandings of the inborn attachment functions of the infant and their interplay in optimal infant/caregiver relationships in the first year of life.[4–7] In mutual gaze transactions, the caregivers' facial expressions stimulate and amplify the positive affect, the joy, of the infant. The experience of interpersonal oneness in joy is a source of vitality,[5] aliveness,[8,9] and vigor[10] for the infant, which the infant seeks to reactivate. Around the end of the first year of life the child is able to remember these socioemotional

Received June 22, 1999; revised September 3, 1999; accepted October 4, 1999. From the Department of Psychiatry, University of New Mexico School of Medicine. Address correspondence to Dr. Severino, Department of Psychiatry, University of New Mexico Health Sciences Center, 2400 Tucker NE, Albuquerque, NM 87131.
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experiences. These memories of past experiences, named *internal mental representations*, serve as model behaviors in new interpersonal encounters throughout life. Empathic selfobject experiences, then, are sources of vitality that result in the maturation of a person with a whole self, a person with integrity.

Whereas empathic attunement results in a state of joy and excitement, misattunement results in a drastic diminution of joy and excitement. Interest, enjoyment, exploration, activity, and eye contact stop. These misattunement events create an experience of the mother as a stranger and the infant as deficient. These experiences of misattunement may be understood as shame experiences. Shame experiences result from the sudden awareness that one is being viewed differently than one anticipated. In a shame experience, there is a split in awareness. The self is simultaneously experienced as deficient, helpless, confused, exposed, and passive, and at the same time is experiencing the shaming other as if inside the self. The other is experienced as powerful, overwhelming, judging, and right. Unrepaired shame experiences result in a self defined in shame. The shame self leads to a preoccupation with the feelings, behavior, and concerns of the other. This is a "false" self that experiences disorganization and an inability to regulate itself.[11]

The state of wholeness (i.e., of integrity), resulting from experiences of mutual empathic attunement, can be understood as the origin of desire. Desire is a longing to reactivate the vitality and aliveness that was experienced in early infancy oneness-in-joy interactions. The empathic reciprocal shared looking, smiling, touching, and cooing between infant and caregivers grow into the adult choice of sharing because of the sought-after affect of joy in bringing pleasure to and experiencing pleasure with other persons.[12] The self developing within mutual empathic attunement and the experience of repaired misattunement will develop with integrity and a reliable capacity to accurately read the interpersonal environment. In addition to being able to judge social situations with clarity, this person with a whole self will also be capable of providing empathic attunement with others, which is the basis for a healthy conscience.

The state of shame (i.e., of ruptured integrity), resulting from experiences of misattunement that are overwhelming and unrepaired, can be understood as the origin of learned patterns of interpersonal connections based on fear—fear of losing the other, fear of losing the love or approval of the other, fear of being unlovable, fear of punishment by the other, and fear of not living up to one's ideal for one's self. These misattunement states may be lived out in a counterphobic manner wherein the importance of relatedness is denied.[13] These patterns, when internalized, can result in a kind of social blindness that emerges from the person's desperate seeking for selfobject functions in adult relationships. Impetuousness, in fact, undermines the access of true self intelligence required to judge social situations reasonably clearly. The person living in a state of ruptured self is preoccupied with feelings defined in shame. The self is simultaneously concerned with its own emotional pain and lack of adequacy, and overwhelmed with concern about the other as one who controls the self experience and well-being.

We present a case illustration of an individual who demonstrates a self predominantly developed within misattunement. The case demonstrates the shame state, manifested as depression, which is punctuated by experiences of hypomania when others are discovered who can serve as effective selfobjects. This case illustrates the social blindness that results from the ruptured integrity in states of both depression and hypomania. Following the case presentation, we discuss our understandings of the case within the framework of attachment functions.

CASE ILLUSTRATION

A 59-year-old, four-times-divorced homosexual lawyer sought treatment for worsening depression after resigning his job in public sector law. His prior depression resulted in two serious suicide attempts by overdoses, 10 and 20 years previously. He recently moved to town after receiving a letter of reprimand from his boss, who "scolded" the patient for a "litany of trivial complaints" such as spending too much time sitting on the toilet with reading material. This, coupled with his decision to leave his significant other of 10 years, whom he described as a man with untreated "paranoia" and a "drinking problem," contributed to his current depression, which was accompanied by vegetative symptoms, guilt, and passive suicidal ideation.

Despite treatment with antidepressants for 5 months, the patient needed admission (the first of multiple inpatient admissions) plus partial hospitalization, during which time he received electroconvulsive therapy treatments. When the patient began the partial hospitalization program, J.S. began seeing him for weekly long-term therapy to help him answer his question, "Who am I?"

The patient reported that mother's pregnancy with him was "difficult," ending in a cesarean section at term. Mother "didn't have enough milk" and thus "did not nurse at all."

Developmentally the patient met major milestones on time, if not a bit early. He related family stories that at age 3 to 4 he was difficult to control, requiring a harness with a leash, which he described as "common in those days." A little before he turned 5 years old he began Catholic school, which he says he hated: "I was mentally ready, not socially." He remained at that school until the eighth grade. One of his earliest memories was of an incident when the schoolchildren lined up, as they usually did, in order of their size, the patient being the smallest of his classmates. He tripped a classmate who was holding a large glass dish in his hands. The child fell and the glass broke in his hands. The patient said that even after these many years he still felt guilty about this, that it was mean, that it was a joke, and that he didn't even know his classmate.

An incident that occurred when the patient was around age 10 exemplifies the kind of relationship he had with his emotionally distant mother. He had picked up a stray dog and asked his mother if he could keep it. She ran an ad in the newspaper and after a sufficient time no one claimed it. He named the dog Pal. Two years later a man claimed that Pal was his dog. The patient's mother and this man decided that since he, too, was Catholic, they would bring the issue of rightful dog-ownership to the priest. The priest decided that the dog was rightfully the first owner's and that the patient must give it back. He cried for days after that, feeling that he had lost a good friend. He was furious with his mother "for being a goddamn wuss" and the priest "for making a wrong moral decision."

In high school he found a niche in the family as his mother's confidante. His maternal grandparents lived upstairs when they got older. The grandfather would pick fights with the patient's mother, and the patient would then run to her defense. She shared with her son that she was not interested in sex, that she stayed up late watching television to avoid sex, and that "it was painful for her." The patient explained to his mother about her intact hymen as what he "knew" to be the cause of her dyspareunia. This role of confidante went on for years and gave the patient a sense of power, which he thought he liked. His mother, however, was not a confidante for him. He could not go to her with his concerns. One time he tried to confide in her that he felt lonely and isolated at the Catholic high school his mother insisted he attend. She told him curtly to "get a job."

The patient's father ordinarily spoke but a few, cursory words to his son, mainly for propriety's sake. The father ran the meat department of a local chain supermarket, worked long hours, never arrived home until 7:00 P.M., and went to bed religiously at 10:00 P.M. He never had both weekend days off—and when he was at home on Sundays he would indulge in his hobby of remodeling the house, to the detriment of his relationship with his son. The patient says that "he didn't ignore me," but "there just wasn't much of a relationship with Dad." When the patient was 12, he asked his father to help him put a go-kart together. This, he thought, would enlist his father's attention and affection in a project with him. Instead, his father disappeared into the basement, emerging hours later with a completed go-kart. The patient told me explicitly, "It was the companionship that I missed." He mentioned many examples of this behavior (in college and beyond), where his father's seemingly well-intentioned actions lacked the vital give-and-take of a healthy, mutually satisfying father-son relationship.

The patient was terribly afraid that his father would speak poorly of him. In eighth grade, he delivered the morning newspaper, getting up at 5:00 A.M. in the winter and working through the spring. He was eventually fired—for reasons that were unclear to him, then as well as now. The only thing he could think of was that there was one Sunday, well before he was fired, when he overslept. When he was asked to leave he cried and carried on, hoping desperately he could keep working—mainly so that he would not have to face his father. His boss conceded at that time, briefly, allowing the patient to deliver the afternoon paper. He was, however, eventually fired from that job. The patient pleaded with his mother not to tell his father. He felt that he was not living up to what he "was supposed to be," and he developed a "fear of not doing a job right." Two issues are exemplified here: 1) the patient's long-standing sense of inadequacy in comparison with his father, and 2) his inability to read social cues or understand how he could have precipitated his firing, either as an eighth-grader or as an attorney in midlife. Even more pertinent was the patient's actual use of the word "shaming" to describe the lengths to which he had to go to conceal the firing from his father—to avoid unbearable shame.

At about age 16, when the patient was in a preparatory seminary for the priesthood, he met a friend, Bob: "I finally had a buddy." They cut class together occasionally and never got caught. They called in sick for each other and even signed notes infrequently for each other. Once the patient and Bob were called into the Monsignor's office. Bob went in first and came out angry. The patient went in and did not understand what the priests were getting at. Later Bob explained to him that they were asking them if they were gay.

In adult life the patient's relationships with women typically took the same form: he would unhesitatingly marry a woman, not out of strong physical or emotional attraction—in fact, he says that he well knew even before his first marriage that he had absolutely no sexual feelings toward women—but rather, out of a satisfaction of "shoulds" and because "it was the thing to do." The patient described these relationships as a consequence of his "rational decision making" and said that "emotions don't enter into it." The patient dated because it seemed to him that if he didn't, "you would be queer." The patient accommodated in order to avoid anticipated shame. He was terribly afraid of his family's rejection, particularly his father's.

His first marriage, to A., which lasted 8 years and produced both of his children, was characterized by a good friendship, but, as the patient noted, it was sorely "missing something." His fantasies about men provided the impetus for erections necessary to continue sexual relations with A.

He experienced sex as a chore and was angry that they couldn't use birth control because of the Church rules: "I wanted to send the Pope the child support bill." The patient decided to go to law school, and he graduated at the top of his class. Shortly thereafter he picked up a male hitchhiker for anonymous sex and then began frequenting gay bars while attending law conferences out of state. The patient met a man who was openly gay with whom he spent a weekend in a hotel: "It felt like love." However, he was wholly shame-ridden, and when the maid inadvertently opened the hotel room door as they were getting into bed, the patient believed that he would be arrested. Dramatically, he experienced a shift of ego state precipitated by "being seen"—shifting from elation into overt shame. Prior to returning home the patient got drunk for the first time ever, making his wife suspicious that something was wrong. In the ensuing days, A. found and read his diary in which was detailed his experience with the man he had met.

The discovery of his secret prompted A. to urge the patient to see a psychologist to "help me adjust." In the meantime, he would occasionally go to gay bars but would shake and shiver, too frightened and shame-ridden to make contact. He reexperienced acute shame on multiple levels of awareness at these moments, fearing intolerable abandonment and loss of all attachments. At 31 years of age the patient became profoundly depressed for the first time in his life and felt suicidal, on multiple occasions driving 125 miles an hour on the freeway. He was quite confused, yet he was still able to maintain a job as a lawyer. He and his wife discussed his interest in having relationships with men, and A. said that she could live with it if he did it occasionally. However, the patient "couldn't live with that." Soon thereafter, A. asked for a divorce. Had A. not asked for a divorce, the patient assured me he would still be married to her, since he loved his children and was very concerned about them.

His subsequent relationships with women were considerably briefer, and each was precipitated by the patient's desire to convince himself that he was not gay—that is, that he was acceptable. He told himself that perhaps it was his particular wife: "Maybe A. wasn't the right woman." All of his wives were similar in their desperation for a relationship and in their prolific sexual activity.

His relationships with men were also troubled. He had struggled for years to find a same-sex soul mate, and the closest he had come to this was his relationship with Bob, the boy in the seminary with whom he cut class and gallivanted around town. Always he felt he was "looking for love in all the wrong toilets." His longest ongoing relationship had been for 10 years with C., who was a hitchhiker whom the patient picked up. He described C. as an alcoholic with a low-grade, chronic, untreated paranoia. He spoke little about him except to say that he really had failed to be a partner and the sort of "buddy" for whom he had longed. C. was reclusive, often cold and clinical (especially regarding how he behaved sexually), and ashamed and embarrassed by his own sexuality. The patient admitted to his frustration with C. Because he loved C., however, he could not easily let him go—he worried about him too much. His continued relationship with C. appeared to come out of an identification with what the patient perceived as C.'s need and desire for emotional rescue. In addition, the "shoulds" at work in this relationship came from primitive experiences of the shamer as being "right," which produced a deep sense of inadequacy and of inability to know or be right himself, with the resultant desire for a redeeming merger.

Other contemporary behaviors reflected the patient's desperate search for connectedness with a "buddy" who could create a feeling of energy. The most glaring example during therapy occurred in a relationship he developed that ultimately led to his participation in a crime. Two weeks after the crime, the patient was able to put his relationship with this person in perspective, understanding that his hunger for relationship was so intense that he allowed himself to be party to a crime in which he was not overly invested, and one that was certainly "out of character" for him. As in previous circumstances in his life, the patient became energized by the other, permitting himself the freedom to abandon the norms, values, and rules by which he ordinarily lived. In these mergers there was freedom, a disavowal of experience of the self as shamed, and a loss of observing capacity, thus rendering shame no longer able to inhibit his desires. He was so elated to have this buddy that he suffered even greater social blindness. The patient became deflated and ashamed at what he had done, realizing the effect it was now having on his sense of himself as a person, his integrity. "It was a cure for loneliness" is how he later understood his impulse to connect at any cost.

The therapeutic reflection on the crime became the turning point in our work, permitting questions about the social blindness that had enabled his troubled relationships. How could he have been so unseeing (even as a lawyer, for goodness' sake!) of the serious consequences of his behavior when he had ample time to consider beforehand whether or not to participate in this swindle? In therapy, the patient began to understand how shame diminished or changed the observing capacities of his true self.

In the transference relationship, there was an observable progression from social blindness to a kind of twinship, with resultant healing. As the patient took me through his early adolescence, he described a boy with whom he became sexually involved in the sixth and seventh grades. He downplayed any emotional attachment to this person. He described in some detail how they would get together and mutually masturbate while verbalizing fantasies about men. At the next session the patient began as he usually did, picking up the chronology from where he had left off. A slip of the tongue indicated his positive feelings for me:

PATIENT: Where were we? . . . Oh yes, I was telling you about how I masturbated with Jimmy Spiegel. He lived a block away and we played together.
THERAPIST: Who was it that you played with?
PATIENT (without hesitation): Jimmy Spiegel.
THERAPIST: That's interesting . . . because, as you know, I'm Spiegel.

PATIENT: No, I'm certain it was Spiegel. Jimmy Spiegel . . . well, I suppose it could have been Siegel. Siegel or Spiegel.

Weeks later, and without observable affect, the patient stated as an afterthought at the tail end of a session, "Oh, by the way, the other kid's name was Jimmy Sobel."

His positive transference continued as a healthy, stabilizing, vitalizing twinship with me. Mirroring and idealizing transference experiences made possible an increasing awareness of his impaired social judgment related to shame states. It was the healthy selfobject merger in various moments in the therapy that served to energize him and to allow his healing. For example, he insisted on telling me his entire story in a way similar to the type of film where events are narrated by a first-person, subjective off-camera voice, reminiscing and detailing what one is about to see played out on the screen. The detail of important conversations and situations was such that the images were easily impressed on my mind. When I asked from time to time about this process of revealing his story in a fiercely chronological way, he would say with emphasis, "I need you to know this. It gives me a sense of accomplishment."

In descriptions of his life history as well as his more recent experiences, he would use at times absolutely outlandish, irreverent, and downright vulgar descriptions of people and events, which had tremendous comic appeal to both of us. Looking back at what had occurred, I realized that what I was responding to primarily was not the exact details of his descriptions, but rather his own laughter that accompanied his witticisms. This sort of "bad-boy" irreverence was infectious, and I thoroughly enjoyed these brief flights into pleasure with him, momentarily freed from the shame that bound him, with a therapist-"buddy" in a safe, structured relationship. It was in a sense a "contained hypomania." Unlike his usual manic defense, this hypomania was especially brief (lasting a few moments), existed within the therapy, strengthened our relationship, and thus promoted healing. As I laughed, he experienced my pleasure; his eyes widened to my joy in him. He began to see the enlivening effect this connection was having on him.

This strengthening of the therapeutic relationship through joining the patient in laughter allowed me to explore with him transference derivatives of the various emotions he experienced at this time and throughout the treatment process. In other words, the mirroring and idealizing transference experiences were the first important step in a complex process of analysis of the patient's shame. It is the importance of this first shared experience, however, that is the primary focus of this report.

A touching episode in the relationship with the patient was a time late in the course of therapy when he excitedly shared with me his rescue of a dog from the Humane Society pound. With a triumphant tone, he described how good he felt with this new dog in his life, specifically stating that this was an attempt to recapture what he had enjoyed when, as a child, he cared for Pal. Several minutes after one session the patient spotted me leaving the building from several yards away and called out to me, "Dr. Spiegel!" I turned and watched my patient run to me with the dog on his leash. He abandoned subtlety for the greater good of involving me in his enjoyment of this animal (which I did not hesitate to pet). I viewed the dog as his transitional object. To have me associated even for an instant with his beloved pet became necessary for him in a kind of magical way, requiring that I actually meet the dog in person. Within the next couple of weeks my patient began meeting and socializing appropriately with other men his age.

A few months before the end of the therapy, the patient's father died. This event left the patient with minimal emotions: "I probably should be sad, but I'm not. I don't feel a loss because there just wasn't much of a relationship there. If anything, I feel just like when my mother died . . . a sense of relief." The patient used his session with me to reflect on his father, and on the fact that he had no urge to cry upon hearing the news of his father's death, at the funeral, or at any time thereafter. The next week he announced that he would be going on a vacation out of state to a national monument he had always wanted to visit. In our few sessions together before the trip, the patient appeared to be leaving his depression behind while hopefully and excitedly anticipating his trip. He went with C., his "buddy." Three weeks into his trip he called the office to let me know that he was having a great time and that he would not be able to make the next appointment, and that he would call the week following to arrange an appointment. The patient never did call that next week. While it was unclear what precisely had happened, the original message he left and his fulfillment of a long-abandoned desire led me to feel optimistic. Specifically, as has been described by Viederman,[14] this patient's object loss (literal loss by death of father) seemed to result in a personality change and growth by undoing previous identifications with the lost object that had been inhibiting him and had prevented personal growth. His father's death had freed the patient up.

He did appear for another appointment several weeks later. He said, "I finally took the trip that I have always dreamed about—this was it!" An enthusiastic patient told me that he had purchased a new, top-of-the-line trailer of which he was proud, a trailer that his now-deceased father could not criticize. He remarked, "With Dad gone I felt that I could do whatever I wanted to, so I bought this beautiful trailer. If he were still here I would probably have shown it to him, he would have said something bad about it, like, 'It's not worth that much,' and I would have been forced to take it back. Things are different now."

The considerable freedom his father's death afforded him was not limited to shopping. The patient explained to me that his relationship with C. was the best it had been in over 10 years and that they planned to purchase a piece of property where they could live in their new trailer together in peace and privacy. He was angry at himself and at his father when he told me about this realization: "Every Christmas I would come and visit Dad when I really should have been spending them alone with C." He described one

Christmas from years ago when he and C. and another couple had dinner together at home—the one time he did not go to his father's house. The patient said that it was thoroughly enjoyable and "it made me feel whole." He vowed to himself over his recent vacation to conduct the rest of his life as he had during that one Christmas when he operated out of his own desire. He acknowledged that it was already much easier to discern his own from an other's desire now that his father was dead. He added that he felt so very alive and he "knew" that he no longer required antidepressant medication. He told me he had discontinued his medication 5 weeks prior to this session and had felt "alive and myself" ever since.

The final months of treatment were spent exploring the patient's feelings about loss of his therapist. During this process, the patient both consented to the publication of this paper and actually read the paper. This allowed a reworking of many issues, including aspects of his relationship with C.

UNDERSTANDINGS

This patient's shame-based identity developed largely from his experience of his mother's and father's repeated failures of empathic attunement. Although there was no loudly proclaimed shaming (i.e., an explicit expression of negative sentiments toward their son, such as "You disgust me" or "You're worthless"), there were acutely shaming rebuffs of the patient's desire for empathic closeness. These interpersonal rejections worked insidiously to create shame experiences, resulting in a self defined as defective, a self ineffectual in stimulating empathic connectedness, and a self at the mercy of unpredictable and uncontrollable outside circumstances. His attachments to others in life became determined by his fears, primarily his fears of losing the love of the other and of disappointing his ego ideal. Much of his adult life was lived out in a state of depression, ranging from dysthymia to major depression.

His poorly developed social sense manifested itself in a life full of tenuous and precarious relationships and situations involving individuals who were struggling with their own problems. His unmet yearning for vitalizing empathic attunement left him highly vulnerable to experiences of selfobject merger. When he chanced to find someone with whom he could experience this merger, he shifted into periods of hypomania. These periods were immediately gratifying, were freeing from depression and overt shame, and sprang from an irresistible desire for the living other before him, a desire to get into the energizing experience of the other. In these intoxicating hypomanic states, the nature of his social blindness shifted. There was an evaporation of conscience that permitted the bending and breaking of established rules. (For a literary example of the process, the reader is referred to the description of the internal life of the criminal in Fyodor Dostoevsky, *Crime and Punishment* (1866), part 1, chapter 6 [New York, Random House, 1993, pp. 70–71].)

This phenomenon has been described by Klein as a manic defense: "These feelings are directly related to, and defensive against depressive feelings of valuing the object and depending on it, and fear of loss and guilt"[15] (p. 83). Where Klein uses "guilt," we would use "shame." Furthermore, Segal,[15] commenting on Klein, observes:

> Since depressive experience is linked with an awareness of an internal world, containing a highly valued internal object that can be damaged by one's own impulses, manic defenses will be used in defense against any experience of having an internal world or of containing in it any valued objects, and against any aspect of the relation between the self and the object which threatens to contain dependence, ambivalence, and guilt. (p. 83)

The patient's "shoulds" did not operate in those hypomanic moments, and he defied rules without regard to consequences. He was reprieved from his fears (both conscious and unconscious) of not living up to his ego ideal and of losing the love of the other (his father) during the brief periods of selfobject mergers. In those moments of connection there was a surge of feeling for the other, a revitalization as if the patient had wholly and instantly escaped the burden of the shamed self. These were moments of intoxication that resulted from the patient's fulfilling his desperate need to experience good selfobjects. This enchanting experience, which was immediately attractive and exciting, superseded his otherwise shamed, depressed internal reality. This manic defense—a brief awakening of his grandiose self—blinded him. Over the years this pattern of the "intoxicating coalition," invoking the manic defense, allowed him to serve as his mother's confidante/therapist; pull capers with his high school buddy (cut class, violate rules of the church); go to X-rated bookstores to rent videos with another married man; pick up men at gay bars or hitchhikers even while married; connect with needy, unstable women; tell inappropriate, self-deprecatory jokes in therapy groups; and, most dramatically, commit a crime.

Although committing crimes per se had not been the patient's pattern, this remarkable behavior was only

seemingly out of character. Such behavior in this patient resulted from an internalized shame state that was accompanied by a gnawing yearning for relief from this state and a desire for mutual relatedness. The hypomanic, vitalizing merger, in acute contrast to the otherwise unrelenting experience of shame, generated an intoxicating state of "childish thoughtlessness." This state sprang from a self that did not grow up in healthy connection to an important, enlivening other. This lack of healthy connection resulted in underdeveloped self-functions: immature observing capacities, impaired awareness of the subjective life of others, reduced ability to modulate vitalizing connections, and poor judgment of his own and others' motivations and the consequences of behaviors. At such times he experienced a temporary reprieve from depression.

Abruptly, these hypomanic honeymoons would crash when the vitalizing selfobject merger suddenly failed. These failures left him in a daze and with such a numbing of feeling that he became even more uncertain about where he was in the present and where he was going. Depression resumed with even greater intensity, and the "blind" patient fell into a whirlpool, swirling downward and ever further from his true whole self. This is to say that when the hypomanic state ruptures, it recreates an experience of acute shame and a split self state.

The pattern just described has been viewed as psychopathology. However, with an understanding and appreciation of the need for empathic attunement and the desire to rediscover the vitalizing experience of attunement, this pattern can be viewed as a drive toward health. Melanie Klein, for example, defines the hypomanic state as a manic defense that at once blinds the individual to the subjective reality of the other and prevents growth into the next stage of development.

In this case, we can see both the arrested development and the lack of awareness of the other that we have called social blindness. This case, however, demonstrates also the healthy yearning to escape the state of depression and the desire to enter into a vitalizing relationship with another person. In day-to-day life, this desire creates a vulnerability because the person providing the selfobject function is not prepared to understand the dilemma of a person such as this patient. It is in therapy that the selfobject merger can be understood and managed in a way that can help the patient channel this vitalizing energy in the direction of health. Greenspan[16] would view this process as "the essence of the therapeutic experience" (p. 208).

Within the therapeutic relationship, the patient was able to establish a twinship type of selfobject relationship with the therapist. Such a twinship relationship had been a lifelong quest for this patient, and it had led to his repeated defeat and discouragement when potential relationships of this type failed. In the controlled therapeutic setting, the transference relationship allowed the patient not only the vitalizing energy, but also the context within which to observe his social "blindness" and to protect himself from destructive acting out. Within the therapy, the patient experienced positive and safe mirroring selfobject functions that could be internalized.

The literal loss of his father seemed to free up the patient significantly. Death of his father provided him with the opportunity to better recognize his own desire and to better recognize and disregard automatic negative comments from his shaming paternal introject. His father's literal death permitted a figurative death; that is, a diminution of the power of shame-based internal representations. Indeed, shortly after the death of his father he was no longer depressed and maintained his healthy affect even in the absence of antidepressant medication. His ability to free himself may well have been related to the selfobject transference work done in the therapy.

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