Summary of Therapy Session — July 17, 2017

1. I stated to the therapist: “When I was a boy I once said to my mother, “I love my sister more than I love you.” The therapist responded that that was an expression of the “attachment dance.” In the therapist’s interpretation, perhaps I felt that I was not getting the love and attention I needed from my mother, so I attempted to provoke her on the theory that it’s better to get angry attention from mother than no attention at all.

I had a negative response to this interpretation. I felt constrained by her reference to the attachment dance and her assumption, based on this one anecdote, that I was attempting to provoke my mother. There seemed to be no context to the therapist’s interpretation. 1/ There was a “jump to conclusions” quality to the therapist’s interpretation.

I sometimes feel that the therapist has a limited number of tools (or concepts) in her toolbox and that she stretches her few concepts to situations that require more subtlety and depth — that is, a fuller range of tools to explain a particular issue. The therapist keeps coming back to the idea of the “attachment dance” as almost a knee-jerk reaction to any issue involving the dyadic relationship between me and my mother. 2/ She then seems to extrapolate her “attachment dance” model to explain my relationships in adulthood. This is entirely too simplistic and ignores the fact that many aspects of my adult relationships are not simply a concrete revival of early attachment issues with my mother but are, in fact, a reaction to internal objects. This would be especially true in an introjective patient for whom oedipal issues (based on three-party relations involving child-mother-father) play a prominent role. When the therapist invokes the dyadic attachment dance she seems to necessarily confine her concerns to anaclitic issues that involve feelings of helplessness and weakness; fears of being abandoned, and strong wishes to be cared for, protected, and loved in which pre-oedipal, dyadic issues predominate. Dyadic anaclitic concerns are primarily oral in nature, originating from unmet needs from an omnipotent caretaker. Introjective concerns are related to the (more developmentally advanced) formation of the superego and involve the more developmentally advanced phenomena of guilt and loss of self-esteem during the oedipal stage.

The therapist’s invocation of the attachment dance seems to ignore the important, if not overriding, issue of introjective issues in my personality. The therapist’s concern with the attachment dance may be a projection of the therapist’s own oral dependency needs.
The idea of a child provoking the mother to receive negative attention is addressed in classical psychoanalytic theory as an example of “masochistic provocation.” Wilhelm Reich gave the classic explanation of “masochistic provocation.” “Genetically and historically, a deep disappointment in love lies behind the provocation. The masochist is especially fond of provoking those objects through whom he suffered a disappointment. Originally, these objects were intensely loved, and either an actual disappointment was experienced or the love demanded by the child was not sufficiently satisfied. It is already possible to note that a strong need for love goes along with the real disappointment experienced by the masochistic character. This need precludes a real gratification and has a specific inner source . . . . [The masochistic character] cannot endure the loss of contact. When this happens he will seek to reestablish it in his own inadequate way, i.e, by courting sympathy through misery. Many such characters are very susceptible to the feeling of being alone and deserted in the universe.” Reich, W. Character Analysis at 243 and 247 (New York: Farrar, Straus, Giroux, 1945) (emphasis added).

We can see one fault in the therapist’s limited tool box. In invoking the issue of the attachment dance the therapist has ignored not only possible oedipal issues, see n. 2 above, but another tool, namely masochism. What about the role of masochism in my relations with my mother, and the role of masochism in my adult relationships? As the saying goes, “Just because you have a hammer doesn’t mean every problem is a nail.” Not all relationship issues can be reduced to the dyadic attachment dance. I have a concern that the therapist’s toolbox is limited to her own projective needs — perhaps she emphasizes the attachment dance precisely because of her own dyadic anaclitic issues.

Another matter: Leonard Shengold has discussed the issue of masochistic provocation as it relates to the experience of child abuse. Shengold, L. Soul Murder: The Effects of Childhood Abuse and Deprivation at 71 (New Haven: Yale University Press, 1989) (discussing a patient’s provocative behaviors toward the analyst that had its roots in maternal overstimulation). Provocative behavior is not simply reducible to a child’s subjective feelings of lack of love from the mother. Provocative behavior can be attributed to the child’s experience of aggression by parental figures. This therapist, owing to her paranoid schizoid anxiety, would probably feel more comfortable viewing the patient as provoking the good mother (the active agency or bad object, i.e., the object struggling with aggressive impulses) rather than as the victim of aggression by the bad mother (the blameless passive agent or good object, i.e., the object of aggression).
Another matter: What about the child who reacts to subjective feelings of maternal rejection not with masochistic provocation, but by a retreat into fantasy, an outcome that may be prominent in the potentially creative child. I had earlier provided material to this therapist about the fantasy of the imaginary twin, a fantasy that is prominent in the creative. (Significantly, the fantasy of the imaginary twin involves oedipal issues, which the therapist seems intent on ignoring.) “A common daydream which in spite of its frequency has received very little attention to-date is the fantasy of possessing a twin. It is a conscious fantasy, built up in the latency period as the result of disappointment by the parents — and retaliatory destructive impulses directed by the child in fantasy against the parents — in the Oedipus situation, in the child’s search for a partner who will give him all the attention, love and companionship he desires and who will provide an escape from loneliness and solitude. The same emotional conditions are the basis of the family romance. In that well-known daydream the child in the latency period develops fantasies of having a better, kinder and worthier family than his own, which has so bitterly disappointed and disillusioned him. The parents have been unable to gratify the child’s instinctual wishes; in disappointment his love turns to hate; he now despises his family and, in revenge, turns against it. He has death-wishes against the former love-objects, and as a result feels alone and forsaken in the world. Burlingham, D.T. “The Fantasy of Having a Twin.” The Psychoanalytic Study of the Child. Vol. 1 at 205 (1945) (emphasis added). A further element in many daydreams of having a twin is that of the imaginary twin being a complement to the daydreamer. The latter endows his twin with all the qualities and talents that he misses in himself and desires for himself. The twin thus represents his superego. Id. at 209.”

There are disappointed children who will provoke the mother. There are disappointed children, potentially creative children, who will seek substitutive satisfaction in fantasy, as described above.

Finally, I am concerned that the therapist’s interpretation about the issue of provocation is simply another in a line of the therapist’s paranoid interpretations. We can now add to the list of situations where the therapist appears to project her paranoid concerns onto my relations with third parties.

When I criticize past therapists the therapist says, “People who idealize some people devalue others.” Translation: “I feel that you devalue me.”

When I talk about a previous psychiatrist who bragged about his job interview she says, “People seem to feel they need to prove themselves around you.” Translation: “I feel I need to prove myself around you.”
When I say that I loved my sister more than my mother, the therapist says, “You were trying to provoke your mother.” Translation: “I feel you are trying to provoke me with your letters.”

In fact, there are interpretations about my motive for writing letters that do not involve simply the dyadic patient-therapist relationship. What about the possibility that my letters relate to a three-party relationship or three-party fantasy? What if my aim is to memorialize my thoughts about my sessions to allow the therapist to consult with a third party expert about my concerns? Perhaps I am projecting onto the therapist what I would do in her situation in recognition of my limited knowledge: talk to outside experts. (This might be a projection of my superego value that demands that I go beyond ordinary professional standards to meet an inner standard of excellence. 4/) That is an analyzable fantasy or projection in itself. As in the past, the therapist seems unable to conceptualize three-party situations — which raises serious concerns about her ability to analyze oedipal issues. I explained this problem in depth in my previous letter about the session on June 19, 2017 relating to the therapist’s inability to conceptualize a three-party relationship involving a previous psychiatrist, that psychiatrist’s supervisor, and me:

Perhaps there was an issue of jealousy between me and the [previous] therapist based on a three-way relationship. The [previous] psychiatry resident was supervised by Earle Baughman, M.D., a senior psychoanalyst at St. Elizabeths Hospital. I had provided Dr. Baughman a copy of my book Significant Moments. Dr. Baughman is an expert in literature, particularly the writers of the American South, such as William Faulkner. The psychiatry resident often told me about glowing comments that Dr. Baughman made about me, about how much I had going for me. The resident said: “Dr. Baughman often opens your book and reads passages from it to me to illustrate different psychological points.” How did this resident react to his supervisor using his patient’s book as a teaching tool? One wonders.

Perhaps these comments by Dr. Baughman to the psychiatry resident aroused jealousy in the resident and caused him to feel he needed to prove himself around me. These observations point to how shallow and simplistic my therapist’s opinions are. She says she is interested in relationships but she has no feeling for the complexity and subtlety of relationships and seems unable to go beyond her own projections. Apparently, this therapist felt that it was she who needed to prove herself around me and proceeded to project those feelings onto my previous psychiatrist. That procedure was strikingly simplistic and projective. (Dr. Palombo mentioned that my personality showed signs that I was struggling with the effects of jealousy in my developmental environment.
Peter Blos points out that a father’s rivalry with his young son can be an important issue in the dyadic father complex that predates the boy’s oedipal struggle. Blos points out the link between this issue of pre-Oedipal paternal rivalry and the boy’s early fear of maternal engulfment. Fears of maternal engulfment appear to be important in my case. My current therapist failed to see how my possible struggle with paternal jealousy in a previous therapeutic relationship relates to my transference fears of engulfment by her — and in a grossly simplistic fashion points to the issue of my eliciting grandiosity from my previous therapist. Blos, P. “Freud and the Father Complex” at 431. The Psychoanalytic Study of the Child, Vol. 42 (New Haven: Yale University Press: 1987). My sister reports that on one occasion she witnessed my father beating me when I was an infant — perhaps evidence of early paternal jealousy. One wonders how struggles about paternal jealousy molded my character and the possible link to my fears of maternal engulfment. See Blos, above.

2. The therapist asked me if I felt that any of my past therapists had been attuned to me. I responded that I felt that Dr. Palombo, whom I saw in 1990, was attuned to me. I said that I felt that none of the residents I saw at the D.C. Department of Behavioral Health were attuned to me (1996-2015).

I thought that the therapist’s question was somewhat loaded. It is true that I experience a lack of attunement with therapists based on narcissistic pathology. I have an extravagant narcissistic need for twinship, idealization and mirroring. But another major factor in the lack of attunement I experienced with past therapists concerned their limitations. They were all in training and their work was supportive rather than psychodynamic. Three psychiatrists diagnosed me with bipolar disorder, which I don’t have. Two psychiatrists diagnosed me with paranoid schizophrenia, which I don’t have. Clearly, in addition to problems of attunement there was an issue of therapist incompetence. 5/ What does it say about the present therapist that she needs to whitewash the clear inadequacies of her colleagues? Cf. footnote 4/ above.

It appears that the present therapist identifies with the professional standards of my past therapists (her peer group, see footnote 4/, above) and is unable to acknowledge their clear shortcomings. In some sense, this is scapegoating by the current therapist: “The patient has a problem with attunement with therapists whose professional work was not a factor in the patient’s lack of progress.”

It is important to look at why I experienced attunement with Dr. Palombo. As a psychoanalyst he derived meaning from context. None of my past therapists derived meaning from context. Rather, they made ad hoc judgments based on material as it
emerged. Cf. footnote 1/, above. These therapists segmented my reports, appraising fragments of the reports rather than looking for meaning in narrative flow. These therapists had a tendency to “jump to conclusions” and had an inability to withhold judgment. They seemed to say whatever popped into their heads. Also, as a psychoanalyst, Dr. Palombo underwent a training analysis and was therefore able to recognize and filter out his own projective needs. The present therapist seems to have projective needs which she is unable to recognize.

One must also recognize the special needs of intellectually gifted patients and creative patients. The need for autonomy develops early and remains an important part of the personality of gifted persons. Exceptionally intelligent persons want control over all aspects of their personal life. They are frequently described as headstrong and oppositional. From the earliest years, they had an intense desire to do things on their own and in their own way, and they balked at interruptions or offers of help. These qualities will impact the therapeutic relationship. Grobman, J. “Underachievement in Exceptionally Gifted Adolescents and Young Adults: A Psychiatrist’s View.” The Journal of Secondary Gifted Education, 17(4): 199-210 (2006).

It has been observed that if perception is reality, and if each of us perceives the world through our own unique set of senses, it follows logically that no two people’s realities will be exactly the same. Hence, each of us is essentially alone in his or her world. And yet we spend our entire lives trying to make connections and form relationships with other people. Indeed, making those connections and forming those relationships are among the most rewarding aspects of anyone’s life. But that doesn’t change the essential fact that we are the sole inhabitants of our primary world — ourselves. In focusing on my need for attunement alone, the therapist ignores the fact that a therapist has the onus of responding to the patient’s needs with empathy. It is difficult for a therapist to respond empathically to a gifted and creative patient if he or she is not gifted or creative himself.

It is noteworthy that psychological tests indicate that I am an outlier in several important ways:

1. Executive Functioning: I had a perfect score on the Wisconsin Card Sorting Test, a measure of executive functioning and concept formation ability (see below).

2. Intelligence: I scored in the top 2% in overall intelligence and top 1% in verbal intelligence.
3. Psychoticism: The MMPI indicated a significant level of psychoticism.

4. Serious character pathology: The MMPI indicated that I have significant features of avoidant, narcissistic, and schizoid disorder as well as characterological depression. (How many psychiatry residents have significant experience working with serious character pathology as opposed to disorders that can be treated medically?)

5. Temperament: On the Myers-Briggs Test I scored INTJ, the rarest of the 16 Myers-Briggs types, accounting for about 2% of the population. INTJs tend to be highly analytical, independent, and original, with little or no regard for what other people think unless others can prove the value of their ideas.

These factors probably play an important role in my experience of lack of attunement. How many psychiatry residents have experience treating patients with this cluster of personality traits?

Finally, it is important to consider that it is not adequate to say that I experience a lack of attunement without saying more. One must also look at the factors that cause lack of attunement in the form of (1) introjective pathology centering on guilt, need for identity definition and Oedipal issues as opposed to anaclitic pathology centering on interpersonal issues, as well as (2) personality factors associated with giftedness and creativity, such as: autonomy, scientific approach to thinking and learning, dissociative capacity, uncanny intuition, frequent and varied associations, high analytic ability, unusual idea production, curiosity, lack of inhibition in the expression of opinion, unconventional thought processes, tendency to criticize constructively combined with an unwillingness to accept authoritarian pronouncements without overly critical self-examination. A mental health professional who is herself primarily concerned with “abasement, affiliation, and deference (socialization),” see n. 4, above, will not readily empathize with a creative patient. A mental health professional who is exclusively concerned with the “attachment dance” will not empathize with introjective pathology.

Personality Factors Associated with Letter Writing

a.) Need to master experience (Superego Issue)

Some individuals have a special need to master their experiences. For example, in 1943 the psychoanalyst Bruno Bettelheim published the paper “Individual and Mass Behavior in Extreme Situations” about his experiences in the concentration camps. Bettelheim observed that writing objectively about his experiences became his
intellectual defense against becoming overwhelmed by the perturbing feelings engendered by his experience. His desire to make people understand the camps received much impetus from his need to comprehend better what had happened to him while in the camps, so he could gain intellectual mastery over the experience. In the words of Erik Erikson, Bettelheim turned his experience “into a research project.”

In addition to the defensive aspect of Bettelheim’s writing we can perhaps see the operation of superego issues in the form of a scientific approach to thinking and learning rooted in psychological development beyond the dyadic mother-child relationship (attachment dance.) The “why and wherefore” of his experience was important to Bettelheim and he developed concepts to describe his experiences. (Note that high executive functioning is associated with high concept formation ability).

The child’s dyadic relationship with the mother slowly merges into the oedipal triadic relationship with the parents by the end of the fourth year, ushering in a severely conflictual situation for children of both sexes. If identification with the parent of the same sex has been proceeding well, this identification now serves as a stabilizing force, facilitating the temporary surrender of incestuous wishes and the modulation of hostile aggressive wishes towards the parent of the same sex. Sublimation of the sexual and aggressive drive derivatives can now proceed, with curiosity directed towards other areas. A significant landmark during latency is the gradual emergence of a scientific approach to learning and thinking. The why and wherefore of things become very important: concepts of the world and people begin to expand, and the development of reasoning steadily advances. Curiosity about sexuality gives way, under reasonably adequate psychological conditions, to curiosity about the wider aspects of the world, a sublimation of a portion of sexual as well as aggressive wishes that continues into adult life unless inhibitions arise because of psychological conflicts that were insufficiently resolved during the pre-oedipal and oedipal periods. Galenson, E. “Comments.” In: Ostow, M. Ultimate Intimacy: The Psychodynamics of Jewish Mysticism, pp. 144-150 at 150 (Madison, CT: International Universities Press, Inc.: 1995) (emphasis added).

The present therapist seems to be mired in pre-oedipal issues.

b.) Need to Withdraw Libido from Primary Objects and Re-invest in Imagination (Creativity and Dissociation):

The writer Andre Aciman has observed:
The ideal thing for a writer is when he has written all day—with minor interruptions thrown in—but needs to head out to a dinner party. He doesn't want to lose his momentum, but he is also eager to meet friends at the dinner. Half-way through dinner, though, he can’t wait to get back. Yes, he loves his friends, and company is always fun, but how utterly fantastic to get back before midnight, change clothes, and pick up exactly where he left off at seven. If he’s lucky, he may stay up till two in the morning. Something someone said that evening caught his attention. He made a point of remembering it. He’ll use it in a sentence he had written earlier that day.

Aciman talks about the writer interacting with people then returning home and psychologically returning to his inner world to creatively transform his experiences. Does this not parallel the potentially creative infant who interacts with his mother then returns to his inner world to hallucinate the mother’s breast independent of his needs gratifications? Compare the creative therapy patient who interacts with his therapist then returns home to his inner world to work through his therapy experience in letters which summarize and analyze his experience.

[Philip Weismann] believed that the future artist, as an infant, had the ability to hallucinate the mother’s breast independently of oral needs. According to him the unusual capacities of the artist ‘may be traced to the infancy and childhood of the artist wherein we find that he is drawn by the nature of his artistic endowment to preserve (or immortalize) his hallucinated response to the mother’s breast independent of his needs gratifications” . . . . One major concept of Weismann is the ‘dissociative function of the ego’ that he substitutes for Kris’s concept of regression in the service of the ego. With the aid of this dissociative function, the creative person ‘may partially decathect the external object (mother’s breast) and hypercathect his imaginative perception of it. [Might the creative patient decathect the therapist and hypercathect his imaginative perception of her?] He may then further elaborate and synthesize these self-created perceptions as anlagen or precursors of creative activity which must then await full maturation and development of his ego and his talent for true creative expression.’ In simple words, according to Weismann, the child who will become creative has the ability to diverge the energy originally invested in primitive personal objects and to invest it again in creative work.” Arieti, S. Creativity: The Magic Synthesis, at 25-26 (Basic Books: 1976), quoting Weismann, P. “Psychological Concomitants of Ego Functioning in Creativity” International Journal of Psychoanalysis 49: 464-469 (1968). Intellectual productions are not simply reducible to a concrete revival of issues surrounding the child’s relationship with and need for love from the mother. There can be a dissociative basis to intellectual productions resulting from a withdrawal of emotional investment from objects.
c.) Possible Moral Dimension Associated with a Therapist’s Lack of Attunement

The therapist focuses on the patient’s feelings of narcissistic injury or distress associated with a therapist’s lack of attunement. Might there be a moral dimension to a patient’s sense of a lack of attunement?

I observe that in cases of medical malpractice the patient experiences two sources of distress: the physical pain associated with botched treatment but also the psychological distress rooted in a sense of moral outrage. Might some therapy patients, perhaps those with introjective pathology, experience some kind of moral distress in reaction to interpretations that seem wrong? (Note that the word “wrong” has a double meaning, relating to both a lack of factual correctness and a moral wrong.)

Note that an element in many daydreams of having a twin sibling is that of the imaginary twin being a complement to the daydreamer. The individual endows his twin with all the qualities and talents that he misses in himself and desires for himself. The twin thus represents his superego. In psychotherapy the narcissistic patient’s need for twinship, idealization, and mirroring represents the patient’s need for a therapist who is a perfect complement to himself, a therapist who will make interpretations that are fully attuned to the patient’s sense of self.

Compare Jeffrey Masson’s perceived needs upon entering his training analysis: “I knew that the idea of somebody saying ‘Tell me everything’ and meaning it was an unbearably exciting, heady thing for me. That somebody would first allow me to say everything that was in my mind, and then would understand it, promised a kind of intellectual and emotional utopia. It was the connection with another human soul that I was after. J. Moussaieff Masson, Final Analysis: The Making and Unmaking of a Psychoanalyst (Jeffrey Masson had strong selfobject needs).

Does a twinship fantasy in the therapy of creative patients also encompass the notion that the therapist serve as a superego figure? If a creative patient’s twinship needs are in fact associated with the patient’s placing the therapist in a superego role, are there moral implications (or superego issues) associated with that role assignment? What happens when the therapist makes an incorrect interpretation? Is the resulting distress in the creative patient simply a narcissistic injury and narcissistic rage? See McLean, J. “Psychotherapy with a Narcissistic Patient Using Kohut’s Self Psychology Model.” J. Psychiatry, 4(10): 40-47 (Oct. 2007) (Narcissistic rage may occur at times in narcissistic patients, which Kohut believes is caused by a deflation of one’s archaic grandiosity or to a traumatic disappointment in an idealized figure, and this rage can evoke intense
and violent destructive responses.). Or might the narcissistic injury be associated with a sense of moral outrage as well? A psychoanalyst might be able to address the issues with greater depth and insight.

What is notable about my personality is the strong trend of moral narcissism in my behavior in spheres outside therapy where, in my interpersonal relations, I seem to dread living with the corrupted self more than I dread social rejection. Moral narcissists strive to live up to their ego ideal, as Freud would have it, rather than lower the ideal; they are individuals who feel compelled to “commit the truth.” The moral narcissist in his incarnation as a whistle-blower in a corrupt organization has a need to “set the record straight.” Might the moral narcissist in the therapy situation experience a special need to set the record straight? Will he experience a special need to critique every action and interpretation of the therapist to moderate his sense of moral outrage? 6/

Perhaps it is no mere coincidence that the INTJ personality (Myers Briggs typology) has been described as one who is “bent on deconstructing and rebuilding every idea and system he comes into contact with, employing a sense of perfectionism and even morality to this work.”

d.) Need for Selfobjects in the Creative Personality — Transference of Creativity

The transference of creativity, whose defining example is Sigmund Freud’s transference onto Wilhelm Fliess (incidentally, a transference that occurred in the context of a largely epistolary relationship), is a form of transference whose role is to accompany the fluctuations of creativity in the creator.

Initially implicit in Heinz Kohut’s work, this notion was explicitly mentioned by him from 1966 on. The correlative of the importance given to creativity, and a therapeutic factor or the effect of treatment that is not interpreted, it indicates a transformation of narcissism.

Starting with Freud’s self-analysis, Kohut stipulated in “Selected Problems of Self Psychological Theory” that Freud’s relationship with Fliess was not transference in the classical sense—there was no dissolution through insight—but rather a transference of creativity that disappeared at the same time as the narcissistic need. Fliess was a function that filled a void and facilitated Freud’s creativity. During certain creative periods, creators need self-objects in one sector of the self or another, without this necessarily indicating weaknesses in the self. The creator’s narcissistic configurations
are more fluid at certain times, and the other person makes possible regulation of self-esteem and confidence possible.

Transference of creativity, a form of narcissistic transference outside of treatment, brings into play all the notions that come out of Kohut’s theory. Oppenheim, A. “Transference of Creativity.”

I would be interested to know how transference of creativity relates to the special transference needs of creative patients. What special distress is aroused in the creative patient in cases where transference of creativity cannot be achieved?

e.) The Secret Sharer Fantasy — Possible Issue in the Psychotherapy of Creative Patients

The secret sharer fantasy is a fantasy that was first discovered or described by the psychoanalyst Jules Glenn. See, Glenn, J. “Robert Frost’s ‘The Road Not Taken’: Childhood, Psychoanalytic Symbolism, and Creativity.” In the secret sharer fantasy, two creative individuals form a strong emotional relationship and write for each other, symbolically uniting sexually and bringing forth an offspring. Although generally two creative individuals make up the duo, only one of the pair need be creative. It is not unusual for one to maintain the fantasy of the “creative secret sharer.” The secret sharer fantasy is a narcissistic one, in which the double often represents the mother of early infancy with whom one merges and creates. It is also Oedipal in that in fantasy the relationship spans a product—unconsciously a baby. The Oedipal attachment may be of the positive or negative type. It is this layman’s opinion that there seems to be some relationship between the secret sharer fantasy and the fantasy of having an imaginary twin.

I would be interested to know how the secret sharer fantasy might relate to the narcissistic patient’s need for twinship, idealization and mirroring (as described by Kohut), see Marmarosh, C.L. and Mann, S. “Patients’ Selfobject Needs in Psychodynamic Psychotherapy: How They Relate to Client Attachment, Symptoms, and the Therapy Alliance.” Psychoanalytic Psychology, 31(3): 297-313 (2014) 7/, and how the secret sharer fantasy might relate to the transference needs of the creative patient with significant narcissistic pathology.
FOOTNOTES

1/ The therapist made an interesting comment (or admission) as it pertains to her lack of interest in seeing things in context. At one point she said to me, “Instead of writing letters, could you raise issues with me in the session as your concerns arise?” The therapist was projecting on to me her procedure of segmenting my reports and appraising issues one at a time. I, on the other hand, am interested in context. I write letters after the session is completed because this procedure allows me to view the entire session in context.


3/ According to Rank and Freud, the family romance fantasy emerges in an intense and enduring form in the creative. Solomon, M. Beethoven (New York: Shirmer, 1977). When I talk about my sister’s emotional vulnerability, the therapist mildly chastises me, “I get the feeling that you are judging your sister.” Translation: “I feel that you judge me.”

4/ The psychologist Donald MacKinnon gathered personality data on architects. The data clustered into three personality types: (I) the artist (creative), (II) neurotic (conflicted; artiste manqué), and (III) the average (adapted). (Architects were chosen because they combine art with science, business, even psychology). Group I scored highest, in MacKinnon’s analysis, on aggression, autonomy (independence), psychological complexity and richness, and ego strength (will); their goal was found to be “some inner artistic standard of excellence.” Group II scored intermediate on independence, close to (I) on richness, and highest on anxiety; their goal was “efficient execution.” Group III scored highest on abasement, affiliation, and deference (socialization); their goal was to meet the standard of their peer group (i.e., conventional professional standards).

5/ Common misdiagnoses of gifted patients are depressive, bipolar, obsessive compulsive, generalized anxiety, panic, narcissistic and borderline personality disorders. See Grobman, J. “A Psychodynamic Psychotherapy Approach to the Emotional Problems of Exceptionally and Profoundly Gifted Adolescents and Adults: A Psychiatrist’s Experience.” In diagnosing me with psychotic mental illness that I did not
have, five – five! — previous psychiatrists were virtually admitting that they were not competent to treat gifted patients. At GW Napoleon Cuenco, M.D. (and two other psychiatric colleagues) reported that I showed loose associations and flight of ideas, mood-congruent psychotic features of bipolar disorder. The literature states that “gifted individuals think more quickly than others. They make many mental switches, associate rapidly and give the impression that they jump from one subject to the next. “Three of my previous psychiatrists mistook signs of giftedness for psychotic illness! We see this quality of autonomy and a need for originality reflected in the work of creative writers. The novelist Hermann Hesse wrote in the novel Demian, “We can understand one another; but each of us is able to interpret himself to himself alone.” A creative individual with high intelligence will not readily acquiesce in the interpretations of a therapist, particularly a therapist who is not as intelligent as he.

6/ Moral narcissists have been described as persons who take the system more seriously than the system takes itself. Do I take psychotherapy more seriously than other therapy patients? Do I take therapy more seriously than some of my past therapists?

7/ Dr. Marmarosh is a Washington, DC psychologist. She is a Professor of Professional Psychology, Professional Psychology Program, Columbian College of Arts & Sciences, The George Washington University. She is an expert in attachment theory.
SUMMARY OF THERAPY SESSION: July 24, 2017

The following is a summary of my thoughts about my therapy session on July 24, 2017. The thoughts are especially tentative. I do not have a high level of confidence in these ideas.

I started the session by saying that I brought two critiques with me. Last week I had forgotten to bring the critique of the previous week’s session. I said that I also brought a critique of the session on July 17. I said that the latter critique was twelve pages long. “Oh, twelve pages long. Let’s discuss that,” she said. I proceeded to talk about how I continued to be preoccupied with the issue of attunement.

Somewhere into the session the therapist said, “I have the feeling that you want something from me.” “What would that be?” I said. “I feel that you want perfect attunement from me . . .” She proceeded to list other things that she felt I wanted from her. I can’t remember what she said. I said, “Yes, I want all those things.”

In a previous session, I had criticized the therapist’s work. She said, “I don’t know what you’re expecting from me. Do you want me to explain my theoretical orientation?” In that latter case, she attributed the quality of my “wanting” something in response to my oral critique, which she may have experienced as a narcissistic injury.

I note the fact that the therapist is never without her water bottle, which she sips from at least once in a session, seemingly at moments of agitation. The therapist is mildly overweight. 1/

My mind went back to my work with two previous therapists.

In 1991 I was in therapy with William D. Brown, Ph.D. He sometimes commented on my wanting things. I recall that I once mentioned that I had gone to see a movie the previous weekend. He asked who I went with. I said I went by myself. He said, “Would you have wanted to go with somebody?” Dr. Brown emphasized my social isolation in my sessions and frequently encouraged me to get socially involved. It all seemed perfectly reasonable behavior by a therapist: that he would inquire whether I wanted somebody to accompany me to a movie.

The idea of my wanting something emerged from time to time in my sessions with Dr. Brown.
On one occasion he said, “You want Akin Gump (the law firm where I worked) to offer you an associate position.” I said, “No, not particularly.” He said, “Come on, you want them to hire you.” He became insistent about it. I never gave any indication that I wanted to practice law at that firm. At a previous firm (Hogan & Hartson) where I worked as a paralegal I actually went so far as to submit my resume for an associate position. But I made no such effort at Akin Gump. There was no reason for Dr. Brown to insist that I wanted to practice law at that firm. I processed Dr. Brown’s attribution of “wanting” to me as coercive and projective. Was there something that Dr. Brown wanted?

Dr. Brown sipped from soda at our sessions. He once offered me a soda. I once saw him entering the office with a case of soda cans. I interpreted his behavior as expressing oral cravings. Was there some relationship between Dr. Brown’s apparent oral cravings and his insistent imputation of “wanting” to me?

Years ago I was in therapy with a psychiatrist who saw my “wanting” things as a major aspect of my pathology. He said, “You want too much.” At times he would talk about what I wanted from him. I said, “What do I want from you?” He answered, “I know a lot of things about you. You want me to tell you what I know, you want to know the products of my expertise.”

The psychiatrist had noticeable oral cravings. He smoked cigarettes, he sipped water from a mug throughout the session, and he had a refrigerator in the office and snacked on pretzels from time to time. The psychiatrist placed special emphasis on my social isolation. He asked me from time to time why I didn’t have friends. He would always answer his own question. “You don’t have friends because you want too much from people.”

Was there a connection between the therapist’s apparent oral cravings and his insistent attribution of “wanting” to me?

These observations seem to be related to ideas I presented in a previous letter about the current therapist.

“When the therapist invokes the dyadic attachment dance she seems to necessarily confine her concerns to anaclitic issues that involve feelings of helplessness and weakness; fears of being abandoned, and strong wishes to be cared for, protected, and loved in which pre-oedipal, dyadic issues predominate. Dyadic anaclitic concerns are primarily oral in nature, originating from unmet needs from an omnipotent caretaker.
Introjective concerns are related to the (more developmentally advanced) formation of the superego and involve the more developmentally advanced phenomena of guilt and loss of self-esteem during the oedipal stage.” Kemmerer, D.D. “Anaclitic and Introjective Personality Distinctions among Psychotherapy Outpatients: Examining Clinical Change across Baseline and Therapy Phases.” Published Ph.D. Thesis.

Is there some relationship between a therapist’s imputing “wanting,” or craving, to me and the therapist’s own anaclitic, oral cravings.

I also note that the state of envy is a state of wanting. A person who envies another wants something valuable that another possesses. 3/ Is a therapist’s attribution of wanting to me a veiled reference to her feelings of envy, an expression of the therapist’s feelings of wanting projected on to me as a person who wants something? And is there a relationship between a therapist’s feelings of narcissistic injury emanating from a patient — perhaps the therapist feels devalued or undervalued by a patient — and the therapist’s possible resulting experience of envy of the patient and subsequent attribution to the patient that the patient wants something.

That is to say, does the following paranoid dynamic apply in some therapy situations:

I (the therapist) feel you (the patient) devalue me

I (the therapist) envy you (I want something of value from you); I feel depleted by you

Therapist’s resulting interpretation presented to patient:

You (the patient) want things of value from me. You (the patient) want things of value from others

FOOTNOTES

1/ I have strong oral cravings myself. I see myself as having strong introjective qualities as opposed to anaclitic qualities. Drew Westen describes a type of anorexic personality that is preoccupied with food but is also strongly introjective. Westen D., Harnden-Fischer J.” Personality profiles in eating disorders: rethinking the distinction between axis I and axis II.” Am J Psychiatry 2001 Apr; 158(4):547-62. Westen has identified the following introjective qualities in this food-preoccupied cohort: tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects; expects self to be “perfect” (e.g., in appearance, achievements, performance, etc.); has
moral and ethical standards and strives to live up to them; tends to feel guilty; is psychologically insightful — is able to understand self and others in subtle and sophisticated ways (possibly indicating strong self-object boundaries or a high level of individuation); is creative; is able to see things or approach problems in novel ways.

2. I once told Dr. Palombo that I was not interested in having friends. He said, “That’s sour grapes.” It’s as if he was saying psychoanalytically, “You deny your oral cravings.” Yes, that’s exactly what anorexic patients do. They deny their oral cravings. But that overlooks the fact that guilt (or introjective concerns) are a major issue in one cohort of anorexic patients. See 1/, above.

3/ Envy appears to be related to greed. I note that I may have an unusually strong trait of unconscious greed that causes me to soak up the projections of others, tending to make me a scapegoat of paranoid people (including paranoid therapists). Calef and Weinshel found that “[i]n the regression from the oedipal impulses some, perhaps many, people retreat to the introjective (oral) mode of defense. The authors describe, under the rubric of “gaslighting,” an outcome of the introjective defense in which a victim and a victimizer join psychological modes in expressing and defending themselves against oral, incorporative impulses (greed), each in his or her own way.” Calef, V. and Weinshel, E. “Some clinical consequences of introjection: gaslighting.” Are my current therapist and I engaged in an attachment dance in which she plays the paranoid party projecting onto me while I, employing an introjective defense, soak up her paranoid projections? (A word about terminology. Calef and Weinshel are referring to “introjection” in the sense of orality and not in the sense of superego formation.)
**THE RIVER DREAM**

On the evening of July 25, 2017 I had the following dream:

I was swimming in the Schuylkill River in Philadelphia in the direction of downtown Philadelphia. The Philadelphia skyline was growing larger and larger as I approached downtown Philadelphia. I planned to disembark in downtown Philadelphia. I wanted to take the subway home. But I was filled with anxiety: “I have no money. How will I be able to pay the subway fare?” I was caught in a strong current that drew me with ever greater ferocity downstream. I awoke before I reached my destination.

**EVENT OF THE PREVIOUS DAY:**

The Wagner Festival in Bayreuth opened on July 25, the day preceding the dream. The Festival first opened in the year 1876 with a performance of Wagner’s opera, Das Rheingold, the opening of the four-part Ring of the Nibelung.

I have been preoccupied with thoughts offered by my therapist that I am simply acting out through letter-writing activity.

**THOUGHTS:**

Was the Schuylkill River of the dream symbolic of the Rhine River in Rheingold? Were my money concerns symbolic of the Rhine gold, from which the magic ring is fashioned? Was the home that I wanted to return to related to the home of the gods in Rheingold, Valhalla?

Additional thoughts: Does the Schuylkill River of the dream correspond to the River Styx in Greek mythology? In Greek mythology, Styx is a deity and a river that forms the boundary between Earth and the Underworld (the domain often called Hades, which also is the name of its ruler). And what about the Greek god Charon? Does my dream thought “I don’t have money for the subway ride” relate to the following? A coin to pay Charon for passage on the ferry down the River Styx was sometimes placed in or on the mouth of a dead person. Some authors say that those who could not pay the fee, or those whose bodies were left unburied, had to wander the shores for one hundred years. A further association: After Wagner’s death in Venice in February 1883 his coffin was transported by gondola from the Palazzo Vendramin-Calergi where he was lodging to the Venice train station. This began the long passage home to Germany. I am
reminded of the ferryman transporting dead souls by ferry down the River Styx to Paradise (a kind of utopia, see n. 2/, below).

Rheingold opens as follows:

Scene 1 of Rheingold

The scale of the whole work is established in the prelude, over 136 bars, beginning with a low E flat, and building in more and more elaborate figurations of the chord of E-flat major, to portray the motion of the river Rhine. It has been noted as one of the best-known drone examples in the concert repertory, lasting approximately four minutes. The curtain rises to show, at the bottom of the Rhine, the three Rhine maidens, Woglinde, Wellgunde, and Flosshilde, playing together. Alberich, a Nibelung dwarf, appears from a deep chasm and tries to woo them. Struck by Alberich’s ugliness, the Rhine maidens mock his advances and he grows angry. He chases them and tries to catch them in his arms, but they elude him, and tease and humiliate him. As the sun begins to rise, the maidens praise the golden glow atop a nearby rock; Alberich asks what it is. The Rhine maidens tell him about the Rhine gold, which their father has ordered them to guard: it can be made into a magic ring which will enable its bearer to rule the world, but only by someone who first renounces love. They think they have nothing to fear from the lustful dwarf, but Alberich, embittered by their mockery, curses love, seizes the gold and returns to his chasm, leaving them screaming in dismay.


Dr. Conners writes: “The renunciation of love is a theme that has been explored by creative artists in some exceptionally compelling works. T. S. Eliot’s Ash-Wednesday, depicts the sterility of a life in which desire, striving, and wishes for (divine) love are repudiated. In Wagner’s Das Rhinegold, Albench is teased, tantalized, and finally rejected by the Rhinemaidens. He then is presented with an opportunity to steal the treasured Rhinegold, but is told that only an individual who forsweares love may secure these riches. Enraged and humiliated after being dallied with by the Rhinemaidens, Alberich willingly renounces human love and seizes the gold instead, setting in motion the events that will ultimately lead to the twilight of the gods. This article explores the psychology of individuals who, like Alberich, decide that the renunciation of love is preferable to the pain and danger of relationship; instead, they seek control and
mastery over the environment. I use attachment theory (Bowlby, 1969, 1973, 1980, 1988) to illuminate this adaptation and discuss the possibility of altering it through psychoanalytic treatment.”

Scene 2 of Rheingold

Wotan, ruler of the gods, is asleep on a mountaintop with Fricka, his wife. Fricka awakes and sees a magnificent castle behind them. She wakes Wotan and points out that their new home (Valhalla) has been completed.

Psychoanalytic thoughts:

The river was my full bladder. The skyline of Philadelphia was my penis, in an emerging erection — growing larger and larger.

Is there a relationship between my creativity and phallic libido? Upon waking from the dream I had the insights, presented below, about my possible motivation to write letters. Is my letter writing activity, or writing in general, invested with phallic libido? Is my “prolific letter writing,” see Albert Taub, M.D., related to my need to support my maleness and self-esteem?

The money concerns in the dream appear to relate to my desire to resume therapy with Dr. Palombo — paralleling my desire to go home in the dream — but a recognition that I do not have the finances to see him. I don’t have the money to go home. (In fact, Dr. Palombo retired several years ago.)

These are the thoughts I memorialized upon awakening from my dream. The following thoughts, in the context of the dream material, suggest that Dr. Palombo is the imagined recipient of my letters, the idealized father of my family romance fantasy. The letters do not appear to have any relation to my current therapist, except to the degree they are a reaction to my fears of maternal engulfment aroused by the female therapist.

Every week after my psychotherapy sessions I do a write-up of the session, summarizing the work and analyzing our interaction and the therapist’s interpretations. I have the idea the therapist experiences my letters as a hostile enterprise, as if I were attacking her. She believes, I suppose, that I am attempting to provoke or or make her angry.
In a recent letter I stated that her reaction was an expression of her paranoia. I observed that perhaps I wanted to memorialize my sessions — provide her with a written report each week — so that she, in turn, would submit the letters to a third-party expert for review and analysis. That idea was simply an hypothesis.

I have evidence to support the idea that in fact I have a fantasy that one of the motives for the letters is that she will submit the letters to “experts.”

In my application for Social Security Disability Benefits in 1993 I described my paranoid fantasies. One of the enumerated fantasies was that my employer had been submitting my writings “to experts” for review and feedback.

I wrote: “(f.) My former employer has submitted a copy of my autobiography to various experts including Professors Peter Gay at Yale, Fritz Stern at Columbia, and Harold Bloom at New York University and Yale. I believe that my former employer has also consulted and submitted a copy of my autobiography to Dr. Ernst Ticho and Dr. Gerald Post, two local psychiatrists, as well as Dr. Anthony Storr, a psychiatrist in the United Kingdom. (I provided a copy of the autobiography to my current treating psychiatrist, Dr. Pitts.) I also believe that Mr. Robert Strauss, a founding partner of the firm and former U.S. Ambassador to Russia, gave a copy of my autobiography to former U.S. Secretary of State, James Baker in June 1991.”

That’s the fantasy of experts!

I used to think my therapist was paranoid. I now see her as starkly paranoid. She sees everything I do as a reaction to her. In fact, she seems incapable of making any interpretations that do not satisfy her projective needs.

It occurs to me that the fantasy of experts may be related to the Family Romance fantasy described by Rank and Freud. Perhaps, my imagined experts represent the idealized parent who I long for as a substitute for my real parents who have disappointed me.

My therapist disappoints me, so I fantasize imagined substitutes who will gratify my wishes and needs.

The Family romance is a psychological complex identified by Sigmund Freud in 1908, whereby the young child or adolescent fantasizes that they are really the children of parents of higher social standing than their actual parents.
More broadly, the term can be used to cover the whole range of instinctual ties between siblings, and parents and children.

In an early formulation of the fantasy Freud argued for the widespread existence among neurotics of a fable in which the present-day parents were imposter, replacing a real and more aristocratic pair; but also that in repudiating the parents of today, the child is merely “turning away from the father whom he knows today to the father in whom he believed in the earliest years of his childhood”.

Later psychoanalysts have added that the child may turn to imaginary parents of a lower (= uninhibited) social standing; and have seen the essence of the romance in the splitting and doubling of the parents – a dichotomization which hinders the effective working through of the parent complex.

It is important to note that the Family Romance is oedipal in nature and not rooted in the dyadic mother attachment, or the “attachment dance,” as my therapist would have it. My therapist seems oblivious to oedipal issues.

The Dream and Creativity:

Wagner himself has written about his inspiration for the remarkable opening music of Das Rheingold. The inspiration for the music arose in a dream he had one day upon falling asleep on a couch in a hotel lobby in Spezia, Italy.

Wagner wrote:

*After a night spent in fever and sleeplessness, I forced myself to take a long tramp the next day through the hilly country, which was covered with pine woods. It all looked dreary and desolate, and I could not think what I should do there. Returning in the afternoon, I stretched myself, dead tired, on a hard couch, awaiting the long-desired hour of sleep. It did not come; but I fell into a kind of somnolent state, in which I suddenly felt as though I were sinking in swiftly flowing water. The rushing sound formed itself in my brain into a musical sound, the chord of E flat major, which continually re-echoed in broken forms; these broken chords seemed to be melodic passages of increasing motion, yet the pure triad of E flat major never changed, but seemed by its continuance to impart infinite significance to the element in which I was sinking. I awoke in sudden terror from my doze, feeling as though the waves were rushing high above my head. I at once recognized that the orchestral overture to the Rheingold, which must long have lain latent within me, though it had been unable to*
find definite form, had at last been revealed to me. I then quickly realized my own nature; the stream of life was not to flow to me from without, but from within. I decided to return to Zurich immediately, and begin the composition of my great poem. I telegraphed to my wife to let her know my decision, and to have my study in readiness.

In response to my anxieties about maternal engulfment aroused by my current therapist it appears that I have in fantasy attempted to create an idealizing relationship with a former male psychiatrist, Dr. Palombo. In an earlier letter I wrote about myself: “Subject’s object hunger, his idealizing merger needs are fixations on archaic pre-oedipal forms deriving from deficits emerging out of his relationship with an engulfing mother who used subject for her own selfobject needs and in his frustrating relationship with a father unavailable for idealization. Cowan, J. “Blutbruderschaft and Self Psychology in D.H. Lawrence’s Women in Love in Self and Sexuality” (2002). Subject’s idealization of males is a defense against being swallowed up by a woman. See Shengold, L. Soul Murder: The Effects of Childhood Deprivation and Abuse (see especially the chapter, “The Parent as Sphinx”). Subject’s psychology parallels Kohut’s analysand Mr. U who, turning away from the unreliable empathy of his mother, tried to gain confirmation of his self through an idealizing relationship with his father. The self absorbed father, however, unable to respond appropriately, rebuffed his son’s attempt to be close to him, depriving him of the needed merger with the idealized self-object and, hence, of the opportunity for gradually recognizing the self-object’s shortcomings. Cowan, Self and Sexuality at 59 quoting Kohut, H.”

In 1990, during my therapy with Dr. Palombo, I had a dream about him that took place at a hotel. I later recorded the following thoughts or insights about the dream: “In March 1990 I had a dream about my then treating psychiatrist, Stanley R. Palombo, M.D. that I later designated ‘The Dream of the Four Miltons.’ The dream, whose title was an allusion to Milton’s poem, Paradise Lost, was in two parts. A significant image in the first part of the dream was a swimming pool (was bladder urgency and phallic concerns a factor in the 1990 dream as it seems to have been in the current dream?). A significant image in the second part was a birthday cake.

In the interpretation of dreams we look for overdetermination. Freud wrote in The Interpretation of Dreams that many features of dreams were usually ‘overdetermined,’ in that they were caused by multiple factors in the life of the dreamer, from the ‘residue of the day’ (superficial memories of recent life) to deeply repressed traumas and unconscious wishes, these being ‘potent thoughts’. Freud favored interpretations which accounted for such features not only once, but many times, in the context of various levels and complexes of the dreamer’s psyche. Overdetermination works in
two directions: a single unconscious theme can give rise to various expressions in the manifest dream, or a single dream image can be the product of several unconscious themes.

Is it possible that at some level the seemingly unrelated images of swimming pool and birthday cake are related, the product of a single unconscious theme?

What if the two images both relate to the theme of birth? Perhaps the swimming pool reflects the amniotic fluid, while the birthday cake is a direct expression of the theme of birth. (The dream occurred on the evening of March 16, 1990, my niece’s 15th birthday.)

You may ask — so what? So we are dealing with the theme of birth, — what then? What is interesting is that my associations to the dream concern the founding of utopias: the founding of the State of Israel (a utopia conceived by the early Zionists); the city of Hershey, Pennsylvania (a model town founded by the candy manufacturer, Milton Hershey); and Pullman, Illinois (another model town founded by the railroad car manufacturer, George Pullman).

I direct your attention to the work of the psychoanalyst, Wilfred Bion. Bion argues that in every group, two groups are actually present: the work group, and the basic assumption group. The work group is that aspect of group functioning which has to do with the primary task of the group—what the group has formed to accomplish; will ‘keep the group anchored to a sophisticated and rational level of behavior.’ The basic assumption group describes the tacit underlying assumptions on which the behavior of the group is based. Bion specifically identified three basic assumptions: dependency, fight-flight, and pairing. In pairing, the group has met for the purpose of reproduction—the basic assumption that two people can be met together for only one purpose, and that a sexual one’. Two people, regardless the sex of either, carry out the work of the group through their continued interaction. The remaining group members listen eagerly and attentively with a sense of relief and hopeful anticipation.

The hoped for product of sexual union between the pair is a Messiah or Utopia.

Is it possible that ‘The Dream of the Four Miltons’ relates to my wish to unite sexually with my psychiatrist, Dr. Palombo, in the hopes of procreation: the birth of a Utopia?

We can see a possible relationship between the pairing fantasy embodied in Bion’s theory, on the one hand, and the unconscious ‘secret sharer’ fantasy.
The psychoanalyst B.C. Mayer has described the relationship between two creative people in which one influences the other; they write for each other and share an unconscious fantasy of creating together in a sublimated sexual act.

‘The secret sharer fantasy is a narcissistic one in which the double often represents the mother of early infancy with whom one merges and creates. It is also Oedipal in that in fantasy the relationship spawns a product — unconsciously a baby. The Oedipal attachment might be of the negative or positive type.’"

The Imaginary Twin, Anne Frank, and The Birdman of Alcatraz

“A common daydream which in spite of its frequency has received very little attention to-date is the fantasy of possessing a twin. It is a conscious fantasy, built up in the latency period as the result of disappointment by the parents — and retaliatory destructive impulses directed by the child in fantasy against the parents — in the Oedipus situation, in the child’s search for a partner who will give him all the attention, love and companionship he desires and who will provide an escape from loneliness and solitude. The same emotional conditions are the basis of the family romance. In that well-known daydream the child in the latency period develops fantasies of having a better, kinder and worthier family than his own, which has so bitterly disappointed and disillusioned him. The parents have been unable to gratify the child’s instinctual wishes; in disappointment his love turns to hate; he now despises his family and, in revenge, turns against it. He has death-wishes against the former love-objects, and as a result feels alone and forsaken in the world. Burlingham, D.T. “The Fantasy of Having a Twin.” The Psychoanalytic Study of the Child. Vol. 1 at 205 (1945) (emphasis added). A further element in many daydreams of having a twin is that of the imaginary twin being a complement to the daydreamer. The latter endows his twin with all the qualities and talents that he misses in himself and desires for himself. The twin thus represents his superego. Id. at 209.”

Thoughts about Anne Frank cause me to question my therapist’s view that I write letters about my therapy sessions with her because I feel I want something from her, I am not getting that thing, and that in reaction I need to aggress against her: the view that my letters are necessarily an attack on her, calculated to provoke an angry reaction from her.

The teenage Anne Frank and her family were confined to the upper floor of a house in Amsterdam during the Second World War to escape arrest by the Nazis. She recorded her thoughts and feelings about her confinement in a diary. In some sense the diary
was a response to feelings of oppression. The diary was her inner playground and sanctuary. The diary entries were addressed to Kitty, an idealized figure who assumed the role of an imaginary friend. We can surmise that dissociation played a role in the entries to the unidentified Kitty. An actual friend of Frank’s named Kitty Egyedi said in an interview that she was flattered by the assumption she was the real Kitty, but doubted the diary was addressed to her. Kitty Egyedi wrote: “Kitty became so idealized and started to lead her own life in the diary that it ceases to matter who is meant by ‘Kitty’. The name ... is not meant to be me.” May we assume that Anne Frank, in response to the prison-like oppression of her environment and feeling alone and forsaken in the world, retreated into fantasy (or dissociation), creating a relationship with an imaginary figure who would complement Frank, possess all the qualities and talents that she missed in herself and desired for herself? (It’s perhaps important to note that my letters about my work with my therapist are not addressed to the therapist. They aren’t addressed to anyone.) Or should we say rather that Frank’s work was the product of a wish to provoke the Nazis?

Related to these thoughts is the following anecdote. When I was eight years old, my parents took me to see the movie, *The Birdman of Alcatraz*. I was enthralled by the movie and I recall my intense personal identification with the hero.

To break the monotony of prison life, the felon Robert Stroud adopts an orphaned baby sparrow as a pet. This starts a trend and he and the other convicts acquire birds, such as canaries, as gifts from the outside. Before long, Stroud has built up a collection of birds and cages. When they fall ill, he conducts experiments and comes up with a cure. As the years pass, Stroud becomes an expert on bird diseases and even publishes a book on the subject. His writings are so impressive that a doctor describes him as a “genius”.

Notice how my behavior, so rich in suggestive psychoanalytic subtleties, is reduced by a paranoid therapist into the solipsistic and simple formulation: “he is trying to attack me with his letters.”

**Valhalla and the Family Romance Fantasy**

Though psychoanalysis of a dream I had I have been able to determine that a former treating psychiatrist, Stanley Palombo, M.D. is the idealized father in my family romance fantasy.
I wrote above: “These are the thoughts I memorialized upon awakening from my dream. The following thoughts, in the context of the dream material, suggest that Dr. Palombo is the imagined recipient of my letters, the idealized father of my family romance fantasy. The letters do not appear to have any relation to my current therapist, except to the degree they are a reaction to my fears of maternal engulfment aroused by the female therapist.”

The idea of “going home” in my dream corresponds to the home of the Gods, Valhalla, in Wagner’s Ring of the Nibelung. Confirmation for that conjecture is the following letter (reproduced below) that I wrote in 1994 to my then-treating psychiatrist, Dimitrios Georgopoulos, M.D. at GW. In that letter, the gods of Wagner’s Ring — dwelling in their home, Valhalla — are seen as the idealized parents of the family romance fantasy.

These ideas parallel a passage from my book, Significant Moments, where the psychoanalyst Jeffrey Masson writes about an interest in “the family life of the gods.” I then associate, in Significant Moments, to Masson’s chance first encounter with a pair of psychoanalysts — at their home! — while he was an undergraduate student at Harvard. (The passage from Significant Moments is reproduced below).
SUMMARY OF THERAPY SESSION – AUGUST 14, 2017

QUESTIONS PRESENTED:

What does my reaction to the therapist as encapsulated in my letters disclose about the nature of my unconscious wishes, conflicts and prohibitions?

What does my reaction to the therapist as encapsulated in my letters disclose about my interpersonal relations, relational difficulties, and my place in an interpersonal (relational) matrix?

How should a therapist respond to a client’s attempts to peer into the therapist’s personality and psychosexual development?

What might a patient’s attempt to peer into the therapist’s personality and psychosexual development disclose about his unconscious mental life?

Is a patient’s act of writing summaries of his thoughts and perceptions about his psychotherapy sessions a recognized strategy in the treatment of schizoid disorder? How should a therapist respond to a patient who has an exceptional ability and need to sense characteristics, feelings and motivations of significant others in their lives, including therapists?

In a situation where a patient with gifted personal intelligence has intuited non-obvious aspects of the therapist’s personality and psychosexual development, is it appropriate for the therapist to invoke her professional prerogative by barring a patient’s discussion of his insights into her counter-transference?

How is gifted personal intelligence related to the patient’s character pathology? Does a therapist’s act of questioning the absolute right of a gifted patient to write about his feelings, perceptions and thoughts about therapy constitute a form of narcissistic intrusiveness that is adverse to therapy?

Can a therapist who uses relational therapy as an adaptive niche for her anaclitic personality successfully treat a pathologically introjective patient?

Are there parallels between my difficulties in a group situation and my relationship with my therapist that center on my psychological autonomy?
Is the therapist’s negative response to my letter writing, when seen as a negative response to my autonomy, a sign that her response is fundamentally paranoid?

The therapist discloses a lack of knowledge of basic relational principles

QUESTIONS PRESENTED:

What does my reaction to the therapist as encapsulated in my letters disclose about the nature of my unconscious wishes, conflicts and prohibitions?

What does my reaction to the therapist as encapsulated in my letters disclose about my interpersonal relations, relational difficulties, and my place in an interpersonal (relational) matrix?

At some point in the session the therapist said, “I don’t recognize myself in your letters.” I found that to be a curious statement. My letters don’t claim to be oracular reports issued by a neutral observer. I am not a neutral observer. I reveal much about myself in my letters – much that is therapeutically cognizable – through my descriptions of the therapist and the therapeutic process that goes on between us. Like an artist whose portraits reveal the unconscious mental life of the artist even as he claims to portray a recognizable representation of the model (the external object), I reveal much about my internal mental life – my subjectivity – even as I summarize my therapy sessions and describe my therapist. See Blum, H.P. “Picasso’s prolonged adolescence, Blue Period, and blind figures.” *Psychoanal. Rev.* 2013 Apr; 100(2):267-87 (Picasso disclosed the interrelated issues of separation-individuation, unconscious conflict, trauma and melancholic mood in his seemingly realistic portrayals of emaciated, despondent figures, the predominance of monochromatic blue, and his choice of social outcasts as subjects).

Just as I am not a neutral observer with obscure motivations offering objective descriptions of my therapist in my letters, the therapist herself is not a blank screen. “The ideology of psychotherapy has evolved beyond Freud’s “blank screen” therapist. Per the relational model, the therapist is not an objective outsider whose perspective is more “real” than that of the client’s. Rather, the therapist is continually part of the transference-countertransference configurations, with the aim being ‘to broaden the analytic relationship, and by extension the analysand’s other relationships as well, into richer, more dialectical exchanges.’ Therefore, the way in which the therapist relates to others and perceives herself is directly influential to the way in which the therapist will relate to the client, which is paramount to the therapeutic relationship and thus the

I expect to hear the objection that my letters are simply intellectualizations that render their psychological underpinnings incomprehensible. I doubt this is so. By analogy, legal realists believe that even the abstruse legal formulations of jurists are susceptible to psychoanalytical interpretation. See, e.g., Caudill, D.S., “Freud and Critical Legal Studies: Contours of a Radical Socio-Legal Psychoanalysis.” Indiana Law Journal, 66: 651-697 (1991). Underpinning current relational thinking in psychotherapy was Loewald’s emphasis on the significance of the external object (“the artist’s model”) to an early awareness of the inevitability of intersubjectivity. Segalla, R. “Review of Relationality: From Attachment to Intersubjectivity.” J Psychother Pract Res. 2001 Fall; 10(4): 289–290. Intersubjectivity is a complex field that is created when two or more individuals with their unique subjectivities come together. The concepts, terms and inferences of intersubjective theory grow out of the moment-to-moment experience of others and ourselves within a relational matrix of bumping subjectivities. Like a Venn diagram in motion, relationships – including the relationship between therapist and client – are comprised of separate subjectivities dynamically interacting with overlapping influences. In my letters I disclose my subjectivity in my descriptions of my therapist even as the therapist discloses her subjectivity in her interpretations about me.

Intersubjectivity theory has transformed Freud’s view of the therapist as oracular authority, a psychoanalytic view based on Freud’s drive theory. The role of the therapist as a clinical authority and her position as an objective observer of therapeutic events has changed. Nowadays, therapeutic knowledge acquisition occurs largely on the basis of the interactional (relational) events occurring between therapist and client. Radical intersubjectivist-relational approaches not only stress the inevitability of a mutual, reciprocal influence but due to the ineluctable subjectivity of the subjects also exclude the possibility of an objective awareness of the psychological reality of the client. Bohleber, W. “The Concept of Intersubjectivity in Psychoanalysis: Taking Critical Stock.” International Journal of Psychoanalysis, 94: 799-823 (2013).

To insist that when a patient questions a therapist’s personality and professional competence his perceptions of her must be faulty in effect constitutes a “cordon sanitaire” around the therapist. It precludes the unhampered investigation of the patient’s subjective reality, so that the patient’s experiences can be understood in
greater depth, including the therapist’s unwitting contribution to them. It obstructs the establishment of an intersubjective matrix in which processes of self-healing, self-articulation, and self-consolidation can be resumed and realigned. The Intersubjective Perspective edited by Robert D. Stolorow, George E. Atwood, and Bernard Branchaft (1994).

The therapist’s statement: “I don’t recognize myself in your letters” betrays a lack of knowledge of fundamental relational concepts. The therapist claims to have a relational approach to therapy.

THE THERAPIST DOES NOT PERMIT THE EMERGENCE OF PSYCHODYNAMICALLY SIGNIFICANT MATERIAL

QUESTIONS PRESENTED:

How should a therapist respond to a client’s attempts to peer into the therapist’s personality and psychosexual development?

What might a patient’s attempt to peer into the therapist’s personality and psychosexual development disclose about his unconscious mental life?

At the session’s outset I said to the therapist, “You talk about the attachment dance that goes on between you and me and a corresponding attachment dance that went on between my mother and me in childhood. But what about your relationship with your father and how you might replay that in your relationship between you and me?” The therapist explained that I was describing her counter-transference and seemed to say that that was her concern and not mine. She said, “You are shifting the focus.” At the outset of the session I told the therapist that my letter to her this week discussed my ideas about possible issues in her psychosexual relationship with her father. I noted that I had discovered by way of an Internet search that the therapist’s master’s thesis concerned child sex molesters and that the subject matter of the thesis possibly expressed the therapist’s psychosexual preoccupations. I sensed that these ideas made the therapist uncomfortable. We spent the remainder of the hour discussing my letters. The therapist asked me to talk about how I thought she perceived me. She said, “Do you think I don’t like you?” She seemed to be saying that I wrote the letters as a reaction to hurt feelings. I viewed the therapist’s reaction as reflecting her anaclitic concerns, her view that I felt that I wanted something from the therapist, that I felt frustrated in getting my needs met, and that I acted out in reaction; I was acting out by writing letters that would provoke a reaction, even a negative
reaction, from the therapist.
To me, the session highlighted once again the therapist’s inability to place my reports and behavior in an analytic context and her need to give a social, or purely personal, meaning to our interaction. In short, I believe that the therapist personalizes our relationship.

How would a female psychoanalyst respond to my report that I had analyzed her reaction to me as relating to her psychosexual relationship with her father — and my inference that she and I were locked in a psychosexual battle centering on my phallic concerns and her anxieties in relation to male sexual predation?

Perhaps the fictive analyst would think that my perception of these issues was a projection of my own primal scene fantasy — my need to peer into secret facts about the female therapist, my need to view my relationship with the therapist as a psychosexual battle.

In psychoanalysis, the primal scene is the initial witnessing by a child of a sex act, usually between the parents, that traumatizes the psychosexual development of that child. The scene witnessed may also occur between animals, and be displaced onto humans.

The expression “primal scene” refers to the sight of sexual relations between the parents, as observed, constructed, or fantasized by the child and interpreted by the child as a scene of violence. The scene is not understood by the child, remaining enigmatic but at the same time provoking sexual excitement.

Freud persistently strove to decide whether the primal scene was a fantasy or something actually witnessed; above all, he placed increasing emphasis on the child’s own fantasy interpretation of the scene as violence visited upon the mother by the father. He went so far, in “On the Sexual Theories of Children,” as to find a measure of justification for what he called the “sadistic concept of coitus”, suggesting that, though the child may exaggerate, the perception of a real repugnance towards sexual intercourse on the part of a mother fearful of another pregnancy may be quite accurate. In the case of “Little Hans,” however, the violence was explained in terms of a prohibition: Hans deemed it analogous to “smashing a window-pane or forcing a way into an enclosed space.”

The case history of the Wolf Man gave Freud the opportunity not only to pursue the issue of the reality of the primal scene, but also to propose the idea that it lay at the
root of childhood (and later adult) neurosis: the sexual development of the child was “positively splintered up by it.” In his Introductory Lectures, however, he argued for the universality of the fantasy of the primal scene (like the sexual theories of children): it may be encountered in all neurotics, if not in every human being, and it belongs in the category of “primal” fantasies. It appears, however, not to have the same force for all individuals.

Looked upon as an actual event rather than as a pure fantasy reconstructed in a retrospective way, the primal scene had a much more marked traumatic impact, and this led Freud to insist on the “reality” of such scenes, thus returning to the debate over event-driven (or “historical”) reality versus psychic reality. Beyond the issue of the scene itself, however, it was the whole subject of fantasy that was thus raised. It was not merely, in Freud’s view, that the technique of psychoanalysis demanded that fantasies be treated as realities so as to give their evocation all the force they needed, but also that many “real” scenes were not accessible by way of recollection, but solely by way of dreams. Whether a scene was constructed out of elements observed elsewhere and in a different context (for example, animal coitus transposed to the parents); reconstituted on the basis of clues (such as bloodstained sheets); or indeed observed directly, but at an age when the child still had not the corresponding verbal images at its disposal; did not fundamentally alter the basic facts of the matter: “I intend on this occasion,” wrote Freud, “to close the discussion of the reality of the primal scene with a non liquet.”

Melanie Klein’s view of the primal scene differed from Freud’s, for where Freud saw an enigmatic perception of violence, she saw the child’s projective fantasies. Klein considered that a child’s curiosity was first provoked by the primal scene, and that typically the child felt both excited and excluded by the primal scene. The sexual relationship between the parents, fantasized as continuous, is also the basis of the “combined-parent figure”, mother and father seen as locked in mutual (but excluding) gratification.

Where Klein laid emphasis on the way the infant projected hostile and destructive tendencies onto the primal scene, with the mother pictured therein as just as dangerous for the father as the father is for her, later Kleinians stressed the creative aspect of the primal scene; and the necessity in analysis of overcoming a splitting of its image between a loving couple on the one hand, and a combined parent figure locked in hate.
At the current session, did my reference to the therapist’s psychosexual relationship with her father as well as my rudimentary speculations about the therapist’s psychosexual relationship with me point to my primal scene concerns? Did my attempt to peer into sexual issues about the therapist that were out-of-bounds for therapist-client discussion symbolize my drive to peer into my parents’ private sexual relations? Shouldn’t the therapist have been sensitive to the symbolic message, the possible encoded allusion, contained in my communication at the outset of the session? Shouldn’t the therapist have allowed me to develop my ideas – allowed me to formulate a more detailed inquiry – to see where I was going with my ideas? The therapist simply censored me. She cut me off. She changed the subject.

In fact, in my life history, my need to peer into secret facts, my drive – like a small child peering through his parents’ bedroom door in the night — to see things that I am not supposed to see, plays a curious and suggestive role.

In December 1986, while working as a paralegal at the law firm of Hogan & Hartson, I had been assigned to work in my supervisor’s office suite (her “bedroom?”) on a special project for one of the attorneys. I had figured out the computer password of the firm’s computer consultant and I had logged onto a computer without my supervisor’s permission. When the supervisor learned about my infringement she was furious. She said to the attorney for whom I was working: “How much longer is this going to go on? There’s already been a security breach because of him. I want him out of here.” Thirty years later I remember that the computer consultant was named Bob Ferguson and his computer password was “enjoy.”

In 1992 the managing partner and hiring partner at the law firm where I had been employed filed a perjured sworn statement about my job termination with a state agency. The partners’ act of perjury was their dirty little secret. Nobody was supposed to find out about that. But I was able to prove, with abundant evidence documentary evidence, that the sworn statement was in fact perjured. Nobody else – not even the four judges who considered my case – saw what the firm had done, that an illegality had been committed by a major law firm.

I worked as a paralegal at the law firm of Akin Gump Strauss Hauer & Feld from 1988-1991. In late October 1988 I began to believe that someone at the firm was having surreptitious communications with my sister. I confronted my sister about my belief. She denied that such communications were going on. By September 1989 — about a year later — I had deduced that my sister was talking to a senior partner named Malcolm Lassman and I confronted my sister with this belief. My sister seemed stunned and, in the excitement of the moment, confirmed that in fact she had been
communicating with Malcolm Lassman. I was not supposed to know that. But I was able to deduce that it was so. I had peered into the firm’s secret and learned something I was not supposed to know.

An important recurring theme in my book *Significant Moments* concerns an individual’s discovery of secret facts, facts hidden from view. The importance of this theme in the book points to the importance of a personality need to peer into hidden facts.

I discuss Freud’s discovery and elucidation of the unconscious mind which is masked by the ego defense of repression.

I discuss psychoanalyst Jeffrey Masson’s discovery that Anna Freud had deliberately distorted the early history of her father’s work in her edition of her father’s letters.

I discuss Daniel Ellsberg learning the secret history of the Viet Nam War and his act of transmitting confidential government documents about the war to the New York Times for publication.

I discuss Watson and Crick’s discovery of the chemical structure of the DNA molecule (God’s dirty little secret!), a molecule that lies concealed in the cell’s nucleus like a secret document locked in a vault.

I discuss virologist Michael Temin’s discovery of how retroviruses replicate—a controversial discovery that overturned a central dogma of virology.

In sum, my behaviors and intellectual preoccupations point to a drive to peer into hidden facts, possibly suggestive of the operation of a primal scene fantasy in my mental life.

(I had a perfect score on the Wisconsin Card Sorting Test, a measure of executive functioning. The prefrontal cortex (seat of executive functions) is partly in charge of implementing the functions of linguistic abilities and logical deduction. Vaivre-Douret, L. “Developmental and Cognitive Characteristics of “High-Level Potentialities” (Highly Gifted) Children.” International Journal of Pediatrics Volume 2011 (2011), Article ID 420297, 14 pages. My ability to come to understand secret or hidden facts may be the result of both cognitive and psychosexual personality features.)
THE THERAPIST BETRAYS A LACK OF KNOWLEDGE ABOUT ACCEPTABLE TREATMENT STRATEGIES FOR CLIENTS WITH SCHIZOID PATHOLOGY

Question Presented:

Is a patient’s act of writing summaries of his thoughts and perceptions about his psychotherapy sessions a recognized strategy in the treatment of schizoid disorder? My McClendon Center chart states the diagnosis Schizoid Personality Disorder (among other diagnosed disorders). Psychological testing disclosed a significant schizoid trend in my personality.

It is a recognized strategy in the treatment of schizoid disorder to have the patient record his thoughts and perceptions about each of his therapy sessions. The therapist’s attempt to pathologize my letter writing, to view it simply as simply acting out, is anti-therapeutic. The therapist’s devaluation of my letter writing is guilt-inducing and is evidence of the therapist’s limited knowledge.

Ginny Elkin was a troubled young and talented writer whom the psychiatric world had labeled schizoid. After trying a variety of therapies, she entered into private treatment with Dr. Irvin Yalom at Stanford University. As part of their work together, they agreed to write separate journals of each of their sessions. The book Every Day Gets a Little Closer is the product of that arrangement, in which they alternately related their descriptions and feelings about their therapeutic relationship.

THE THERAPIST SHOWS A LACK OF KNOWLEDGE OF HOW TO RESPOND TO A PATIENT WITH COGNITIVE GIFTEDNESS IN THE AREA OF “PERSONAL INTELLIGENCE”

When I was 23 years old (1977) my then treating psychiatrist diagnosed me with borderline personality disorder (BPD). Psychological testing (2014) did not disclose borderline symptoms. I am not currently overtly borderline, though Kernberg states that “underlying borderline organization” can be present in individuals who do not present with overt borderline pathology.

I grew up in the type of family that fosters the development of BPD. My family featured intergenerational enmeshment; my parents displayed continuing high loyalties to their respective families of origin with resultant lack of personal individuation and separation; there was rigid triangulation involving my sister and me – I was the scapegoat (“bad child”) while my sister was the object of idealized projections (“the good child”); splitting and projection pervaded the parent-child subsystem; the
projective identification process within the family system operated in concert with that of splitting to form rigid role assignments and expectations among specific family members; and a high level of marital discord between my parents was projected onto me — I was forced to “own” the projections in order to return the spousal subsystem to a calmer level. See Everett, C.A., Volgy, S.S. “Borderline Disorders: Family Assessment and Treatment.” I also experienced chronic, severe, and pervasive psychological abuse, or “mind abuse,” in my family. Park, L.C. et al. “Giftedness and Psychological Abuse in Borderline Personality Disorder: Their Relevance to Genesis and Treatment. Journal of Personality Disorders, 6(3), 226-240, 1992.

Do I have an unusual capacity for subtle and sophisticated insights about people (including therapists) that is related to borderline pathology?

Park and Imboden (1992) observed that almost all clinicians who have significant experience with borderline patients are impressed at times with their exceptional ability to sense psychological characteristics of significant others in their lives, including therapists. This ability tends to be coupled with the manipulative induction of feelings like those the patients themselves experience, that is, projective identification. Patients may also employ this talent in engendering strong rescue and attachment responses, as well as disagreements, quarrels, or “splits” among those who are involved in their lives, for example, between members of the family or clinic staffs, especially inpatient staffs. “Giftedness and Psychological Abuse in Borderline Personality Disorder: Their Relevance to Genesis and Treatment.” Journal of Personality Disorders, 6(3), 226-240, 1992.

The authors found that chronic, severe, pervasive psychological abuse, or “mind abuse,” is the most frequent and significant form of caretaker abuse (vs. sexual or physical) in the childhood histories of BPD. The authors found that the interaction of a child’s gifted characteristics with the abuse created a tragic drama that is etiological for BPD in a substantial number of cases. The abuse markedly perverted not only use of the perceptual talents (e.g., powerfully compelling projective identification) but overall psychological development.

In the BPD cohort studied there was an inborn talent and need to discern the feelings and motivations of others (intuitive brilliance); the trait was innate and had positive value, and should properly be termed a gift. Much as one would refer to the mathematically gifted person or the musically gifted person, the authors concluded that many borderline patients have a cognitive giftedness in the area of self- and other-perceptiveness called “personal intelligence” but that this gift remains unrecognized
and unavailable in a conscious fashion in BPD patients because it is embedded in the service of self-protection, neediness, control, and rage.

In the BPD cohort studied there was major biparental psychological failure, by combined commission and omission, throughout childhood and adolescence. In addition to the categories of psychological abuse already described, there was in every case a chronic family atmosphere of morbid, disturbing dramas between parents, and/or between one or both parents and the child, usually involving strong negative affects. One of the few softening notes was that the dominant parents generally had grandiose ideas of competence, with malevolence demonstrated in tactics of control rather than in long-term designs of deliberate harm. The children frequently had strong feelings of love and concern (also rage, hate, fear, and so forth) for one or the other, sometimes both, parents, and at times were burdened by a painful wish to take care of and protect these parents.

The authors recommended validating, when appropriate, six major characteristics of borderline patients that are either positive or encouragingly explanatory for BPD: exceptional personal intelligence; history of severe psychological abuse/neglect with concomitant enormous suffering; compulsive self-blame and self-devaluation as attachment characteristics; “staying power”; “real self versus introjected narcissistic characteristics of abusers; and the absolute right to experience their innate capacity for freely enjoying their feelings, their perceptions, and thoughts.

QUESTIONS PRESENTED:

*How should a therapist respond to a patient who has an exceptional ability and need to sense characteristics, feelings and motivations of significant others in their lives, including therapists?*

*In a situation where a patient with gifted personal intelligence has intuited non-obvious aspects of the therapist’s personality and psychosexual development, is it appropriate for the therapist to invoke her professional prerogative by barring a patient’s discussion of his insights into her counter-transference?*

*How is gifted personal intelligence related to the patient’s character pathology? Does a therapist’s act of questioning the absolute right of a gifted patient to write about his feelings, perceptions and thoughts about therapy constitute a form of narcissistic intrusiveness that is adverse to therapy?*
THE THERAPIST’S ADAPTIVE USE OF HER ANACLITIC PERSONALITY IN HER CHOICE OF THEORETICAL ORIENTATION

The therapist shows a high level of anaclitic development with poor introjective development. Her relational approach to psychotherapy – her narrative strategy – appears to be used in the service of her anaclitic (or interpersonal) needs. This can be seen in various of her interpretations.

At a previous session the therapist stated that a therapist’s technical knowledge is not as important as the relationship that develops between therapist and patient. The therapist appears to view the curative potential of psychotherapy to lie in the emotionally corrective opportunities that therapy provides for the patient – emotionally corrective opportunities that lie in the relationship between therapist and patient.

The therapist has consistently viewed my letter writing as a response to my feelings of frustration of my perceived emotional needs in therapy as opposed to a reaction to my inner (introjective) needs for self-definition and autonomy. She seems to say, “You are not getting what you want from me emotionally, so you write letters as a form of acting out to get a reaction from me, even a negative reaction from me.”

At the current session the therapist asked me if I thought she didn’t like me – implicitly linking my letter writing to my feelings of frustration of my emotional needs.

Blatt & Shichman explain that what is common among anaclitic personalities is the preoccupation with libidinal themes of closeness, intimacy, giving and receiving care, love, and sexuality (the therapist’s master’s thesis had a sexual theme). In the pathologically anaclitic, the development of a sense of self is neglected (the therapist is unable to process inner directed behavior — “You write letters because you think I don’t like you”?) as these individuals are inordinately preoccupied with establishing and maintaining satisfying interpersonal relationships. Indeed, as the authors note, the pathologically anaclitic individual’s symptoms “...are expressions of exaggerated attempts to compensate for disruptions in interpersonal relations. These disturbances are manifested in conflicts around establishing satisfactory intimate relationships and around feeling loved and being able to love. The basic wish is wanting to be loved (the therapist stated at this session “Do you feel I don’t like you?”). Blatt and Schichman go on to suggest that this preoccupation stems, in part, from a past in which important others have been depriving, rejecting, overindulging (the therapist gives the impression that she was not criticized in childhood), inconsistent, or unpredictable—thus creating
an environment in which closeness was precarious. Regarding defensive maneuvers, the anaclitic tends to use avoidant ones, such as denial, repression, and displacement. The cognitive processes of the anaclitic tend to be more figurative, focusing on images and affects (the therapist sees my behavior of letter writing as driven by feelings—and not unconscious feelings).

With regard to the therapist’s use of displacement I have previously observed that the therapist seems to project her concerns about me onto my relationships with third parties.

*When I criticize past therapists the therapist says, “People who idealize some people devalue others.” Translation: “I feel that you devalue me.”*

*When I talk about a previous psychiatrist who bragged about his job interview she says, “People seem to feel they need to prove themselves around you.” Translation: “I feel I need to prove myself around you.”*

*When I talk about my sister’s emotional vulnerability, the therapist mildly chastises me, “I get the feeling that you are judging your sister.” Translation: “I feel that you judge me.”*

*When I say that I loved my sister more than my mother, the therapist says, “You were trying to provoke your mother.” Translation: “I feel you are trying to provoke me with your letters.”*

The interaction of the two sources of the therapist’s subjectivity — the therapist’s counter-transference and the therapist’s narrative strategy (her theoretical orientation) — is ambiguous. Either can be appreciated as an organizer of the other. On the one hand, it would seem that the therapist’s anaclitic personality is more basic than her theoretical orientation (her relational strategy). Perhaps her anaclitic personality determines the choice of theoretical orientation as well as the particular manner in which she applies or misapplies her theoretical orientation. Differences of opinion are endemic within as well as between adherents of any particular theoretical orientation. It is difficult to get two Freudians or two Sullivanians to agree in their interpretation of any piece of clinical material. Therefore, the idiosyncrasies of the therapist’s anaclitic personality seem to be the preeminent determiner of her subjectivity. On the other hand, the therapist’s anaclitic response to me is always filtered through the lens of her relational orientation. See Josephs, L. “Countertransference as an Expression of the
Analyst’s Narrative Strategies [with minor emendations].” In essence, the therapist’s anaclitic personality is enmeshed in her relational theoretical orientation.

Question Presented:

*Can a therapist who uses relational therapy as an adaptive niche for her anaclitic personality successfully treat a pathologically introjective patient?*

**POSSIBLE PARALLEL BETWEEN MY DIFFICULTIES IN GROUP SITUATIONS AND RELATIONAL ISSUES BETWEEN ME AND THE THERAPIST**

At the August 14 session the therapist asked me to describe how I thought she perceived me. I said that she probably found me troubling because I didn’t regress in therapy. “You’re a people person,” I said. “People probably respond to you readily. You’re used to that. You probably expected to see that happen in me. You had expected me to respond to you. That never happened. I don’t regress. You’re used to a situation where the patient gives up his ‘I’ feeling and adopts a ‘we’ feeling. I don’t ever come to adopt a ‘we’ feeling because of my autonomy. I think that bothers you. It’s the same problem I have in groups. I get in trouble in groups (i.e., I get scapegoated) because I don’t adopt a group mentality. I don’t regress in a group situation because of my autonomy. I have the feeling that the same thing is happening between you and me. This is a group of two.”

My report to the therapist echoed exactly statements I made in a personality profile I gave in 1999 — almost 20 years ago — to my then treating therapist, Nancy Shaffer, Ph.D. (My comments related to my perception that I had an introjective personality even before I knew what an introjective personality was.)

In that earlier writing I stated:

Subject’s ability to regress in the clinical psychotherapeutic setting is restricted. In the course of therapy, subject’s superego demands and prohibitions are not easily transferred onto the therapist owing to the highly-developed nature of subject’s metabolization of early object relations. Subject’s early relations with the environment gave rise to enduring and stable psychological patterns (structures), which reflect their influence; the early relationships and experiences have lost their specific early qualities and have become assimilated or embedded into his psychic system. Subject’s restricted capacity for structural demetabolization (the aspect of analytic regression that emerges most clearly in the context of the transference) requires a great deal of time, work, and
willingness to overcome. Greenberg, J.R. and Mitchell, S.A. Object Relations in Psychoanalytic Theory at 331 (Cambridge, MA: Harvard University Press, 1983) (discussing the theoretical work of Otto Kernberg, M.D.) Subject’s restricted ability to regress may be especially frustrating for the therapist whose work at a public clinic provides her with considerable experience with severely disturbed patients in whom the emergence of early, unmodulated relationships in the transference occurs quickly because adequate metabolization has never taken place. Greenberg and Mitchell at 331-32.”

QUESTION PRESENTED:

Are there parallels between my difficulties in a group situation and my relationship with my therapist that center on my psychological autonomy?

Is the therapist’s negative response to my letter writing, when seen as a negative response to my autonomy, a sign that her response is fundamentally paranoid?

The psychoanalyst Wilfred Bion theorized that each of us has a predisposition to be either more afraid of what he called “engulfment” in a group or “extrusion” from a group. This intrinsic facet of each of us joins with the circumstances in any particular setting to move us to behave in ways that act upon this dilemma. For example, those of us who fear engulfment more intensely may vie for highly differentiated roles in the group such as leader or gatekeeper or scout or scapegoat. Those of us who fear extrusion more intensely may opt for less visible roles such as participant, voter, “ordinary citizen”, etc. Bion’s idea was that each of us may react upon one or the other side of this dilemma depending on the context, but that the question is always with us of how to “hold” the self, or, put another way, how to assure our personal survival within the life of the collective.

Turquet described the complete loss of identity felt by the individual member of a large (unstructured) group. Kernberg, O. F. “Ideology, Conflict and Leadership in Groups and Organizations.” The individual who fears engulfment will experience this loss of identity or threat of loss of identity as disturbing; the individual who fears extrusion from the group will accept this loss of identity as “the cost of admission” to the group. Do I feel or fear a loss of identity in psychotherapy that I experience as highly threatening to my autonomy? Do my apparent fears about loss of identity in psychotherapy – my resistance to regression in therapy – arouse anxiety or hostility in the therapist?
There is abundant evidence that I do not fear alienation from a group; my anxieties center on loss of identity in a group. Is it this particular disposition that poses difficulties for me in psychotherapy? Am I resistant to the psychotherapeutic relationship because I fear engulfment and loss of identity while, at the same time, I do not fear aggression by the therapist. Additionally, does my therapist have polar opposite concerns? Is she an individual who does not fear loss of identity in a group situation – she will readily acquiesce in the adoption of a group identity – but she fears alienation from the group? Does this possible disposition in the therapist play a role in her psychological reaction to me in therapy?

Two additional factors that play a role in group dynamics might also come into play in my “group of two” relations with the therapist.

– First, Kernberg points out that individuals who retain their autonomy in basic assumptions groups will be attacked by group members. The affect underlying the aggression of group members against the autonomous member is envy – envy of the autonomous person’s individuality, his rationality and his thinking. “Gradually, it becomes evident that those who try to maintain a semblance of individuality in this atmosphere are the ones who are most frequently attacked. At the same time, efforts of homogenization are prevalent; any simplistic generalization or ideology that permeates the group may be easily transformed into a conviction of absolute truth.”

Do Kernberg’s observations apply also to the group-oriented therapist’s psychological reaction to a patient who has a high level of psychological autonomy? Is the affect underlying my therapist’s reaction to me and my letter writing envy – envy of my thinking, my individuality and my rationality? Is the therapist’s use of clichés or simplistic generalizations evidence of homogenization in her relationship with me? I cite the therapist’s use of phrases such as “becoming vulnerable,” “all-or-nothing approach,” and “attachment dance” as evidence of simplistic generalizations or clichés.

— Second, group theory holds that the paranoid fight/flight basic assumptions is anti-intellectual and inimical to the idea of self-study; self-knowledge may be called introspective nonsense. Such groups are characterized by the expression of hatred against all things psychological and introspective. “Organization Change: A Comprehensive Reader,” edited by W. Warner Burke, Dale G. Lake, Jill Waymire Paine.

Assuming a correspondence between a paranoid fight/flight basic assumptions group and my relationship with my therapist – a group of two – one might ask: does my therapist perceive my letter writing as a form of self-study that arouses her hatred? Is
the therapist’s response to my letter writing fundamentally a paranoid response to my thinking, my rationality, and my individuality?
THERAPY SUMMARY: AUGUST 21, 2017

THE THERAPIST IS UNABLE TO PROCESS A PSYCHOANALYTIC NARRATIVE

THERAPIST: How are you?

PATIENT: Not too good.

THERAPIST: Not too good?

PATIENT: Yeah. Summer is coming to an end. We’re coming up on Labor Day. I hate that. I love the summer. I don’t like the cold weather. . . . OK. So, I brought my critique of last week’s session.

[I am referring to a letter I had written that summarized and discusses my last session with the therapist.]

THERAPIST: Let’s continue with what you were talking about.

PATIENT: OK. So I hate the winter. I’m a summer person.

THERAPIST: So why is that?

PATIENT: In the summer I can be outside. There’s a park bench in front of my building. I like to sit there in the summer. I just like to be out and about. But when the weather gets cold, I’m stuck in my apartment. I can’t go out. And I live in a tiny, one-room apartment. It’s so cramped, so confining. I’m stuck in there all winter. And also, there used to be a park outside my building. I would look out my window and I would see the park. Now, there’s just a wall across the way from me. All I see is a wall.

[When I refer to the wall am I referring to the therapist sitting across from me? Do I feel walled in by the therapist? Do I feel I am talking to a brick wall?]

In about the year 2001, they cut down all the trees in the park and they built an apartment building across the way. So now I feel more confined than I used to. Maybe if I had a bigger house I wouldn’t feel so confined.

[My emphasis seems to be on feelings of constriction and confinement, rather than loneliness. I did not say, “Maybe if I had friends I wouldn’t feel so distressed.”]
Looking out at the park I used to imagine that I was Henry David Thoreau living in his cabin.

[Perhaps a psychodynamic therapist would note the element of dissociation in this statement. I am imagining being another person, in another place, in another time. Dissociation can be a symptom of trauma and abuse. Also, there is a relation between dissociation and the ego defense of isolation (splitting thought and feeling); both defenses can be symptoms of abuse and trauma. Blum, H. “Dissociation and Its Disorders.” Psychoanalytic Inquiry, 33(5): 427-438 (2013). My therapists frequently complain that I do not talk about my feelings, i.e., that I employ isolation.

My MMPI results indicated a high level of PTSD and indicated that my profile (Scale 4—psychopathic deviate and Scale 6—paranoia) was consistent with an abusive father. Is my act of imagining Thoreau alone in his cabin (while I struggle with feelings of confinement in my apartment) symptomatic of dissociation and childhood abuse/trauma? Also notable is my reference to a person in another time and another place (Thoreau). Several weeks earlier, I had spent the session talking about H.G. Wells’ novel, The Time Machine. I had given the therapist a letter I had written in 1999 about the novel, a discussion of how the novel might relate to a traumatic injury (broken leg) that Wells had experienced in childhood. The Time Machine concerns a character who traveled to another time, another place by means of a specially-constructed machine. Is there a relation between my earlier thoughts about Wells’ Time Traveler and my report of imagining Thoreau alone in his cabin in the woods? Perhaps a psychodynamic therapist would note all these parallels and ponder their analytic significance.

Also, is my anaclitic therapist registering my struggle with confinement in my apartment as a struggle with loneliness only, that is, is she projecting her anaclitic need for others onto me?]

I used to imagine that I was Thoreau living in his one room cabin on Walden Pond. But now that there’s a wall across from me and no park, I have a harder time imagining that.

THERAPIST: What do you think about Thoreau?

PATIENT: Well, he was an individualist. I identify with him. He was a writer. He wrote Civil Disobedience. He had strong moral values. He ended up in jail because he didn’t pay his taxes[;he was protesting slavery].
[“He ended up in jail.” Note once again the reference to confinement. I talk about feeling confined in my apartment in winter. I associate to Thoreau living in a one-room cabin on Walden Pond. I then associate to Thoreau being confined to jail. Note the veiled allusion to slavery, another confinement or loss of freedom. Previously, I had told the therapist that my father used to beat me as punishment when I was a boy. Perhaps, an astute therapist would say, “You mentioned that your father used to beat you as punishment. Did he also send you to your room as punishment? Were you often confined to your room when you misbehaved? In fact, both my parents would send me to my room for an entire evening when I misbehaved as a boy. I hated that. This was back in the 1950s and early 1960s, before electronic gadgets. There was nothing to do in my room. It was like a prison cell. Perhaps an astute therapist would have thought of that.]

Well, just one night in jail, but he spent time in jail. Also, he had a degree from Harvard, but he ended up not using his degree to practice an acceptable profession. That’s like me too. I have a law degree but I never practiced law.

[Note the issue of personal identification and it’s significance for me. What is the psychological significance of my need for persons who resemble me? Is this related to my selfobject needs, my need for twinship, idealization and mirroring? An individual’s narcissistic need for selfobjects tends to indicate empathic failure by the mother. Does my narrative relate to my feelings about my mother, my need for an idealized substitute (a selfobject) for a mother who did not satisfy my needs? And isn’t there a relation to my letter writing; my desire to have an idealized expert read my letters as a substitute for a therapist who fails to satisfy my selfobject needs? Perhaps a psychodynamic therapist would see these connections.

When I talk about the many ways in which I identify with others – and my obsessive thoughts about these individuals – am I not in some sense talking about my transference needs?

Self psychology, following Kohut, holds that in treatment, the therapist, similar to the early caregiver, serves multiple selfobject functions 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. Marmarosh, C. and Mann, S. “Patients’ Selfobject Needs in Psychodynamic Psychotherapy: How They Relate to Client Attachment, Symptoms, and Therapy Alliance.” Psychoanalytic Psychology, 31(3): 297-313 at 298-199 (2014).

Obviously, it is not adequate to simply say to a patient repeatedly “you have a need for attunement,” as this therapist does, just as it is not adequate for a dentist to say to his patient “you have a need for treatment of your gum disease.” Identifying a problem is not treatment of the problem.]

THERAPIST: So, Thoreau was isolated.

PATIENT: Yeah, but I was disappointed to learn recently that he wasn’t as isolated as I thought he was.

[Note the feelings of disappointment when I found out that Thoreau was not as much like me as I had thought. Am I referring to selfobject failure?]

I was reading a book review of a recently written biography of Thoreau and it said that he wasn’t as isolated at the cabin as we always thought.

[Note the repeated associations to books, reading and writers. I not only intellectualize but I identify with people who intellectualize.]

He actually had dinner once a week with his family, and he had a steady stream of visitors. So he wasn’t as isolated as we always thought. I’m far more isolated than he was. I guess you could say I was a more thorough Thoreau than Thoreau was! I suppose you could say I am more thoroughly Thoreau than Thoreau! [I found this humorous.]

[The therapist had previously mentioned Freud’s book, Jokes and their Relation to the Unconscious. Did the therapist see meaning in my wordplay?]

THERAPIST: That reminds me of another notorious recluse who lived in a cabin, Ted Kaczynski, the Unabomber.
PATIENT: Oh, yeah, the Unabomber! I identified with him too, living in his cabin in the wilderness.

[Once again, we see the issue of personal identification. In fact, the Unabomber was an intellectually gifted individual. He was not simply a criminal, he was a prolific writer, a professor of mathematics with a high IQ.]

[In fact, I was recently rummaging through a collection of my papers and I discovered that I had cut out an article about the Unabomber that was published in the 1990s in the NY Times. The article talked about the intensive FBI manhunt of the Unabomber. Apparently, the FBI investigation into the Unabomber intrigued me.]

Also, the Unabomber was a writer, like me. He wanted to change the world with his writings.

[The Unabomber’s Manifesto, which the NY Times published, was a critique and condemnation of modern industrial society. The Unabomber sought the destruction of modern industrial society through his writings. The writings reflected an alloplastic fantasy, the Unabomber’s wish to change the environment.

Alloplastic adaptation is a form of adaptation where the subject attempts to change the environment when faced with a difficult situation. Criminality, mental illness, and activism can all be classified as categories of alloplastic adaptation. An essential avenue of rejuvenation and to that rebellious expansion of human consciousness which alone can keep pace with the technological and social change. To retrace, as we are doing here, such a step of expansion involves taking account of the near downfall of the man who took it, partially in order to understand better the origin of greatness, and partially in order to acknowledge the fact that the trauma of near defeat follows a great man through life. I have already quoted Kierkegaard’s statement that Luther lived and acted always as if lightening were about to strike behind him. Furthermore, a great man carries the trauma of his near downfall and his mortal grudge against the near assassins of his identity into the years of his creativity and beyond, into his decline; he builds his hates and his grudges into his system as bulwarks—bulwarks which eventually make the system first rigid and finally, brittle.]

Perhaps a psychodynamic therapist would note the autoplastic motivation underlying my letters. I had previously discussed with the therapist my interpretation that perhaps my letters were motivated in part by my desire to change or “cure” the therapist of her limitations as I saw them. The letters in that sense could be seen as an expression of
role reversal in which I assumed the role of therapist and the therapist assumed the role of patient. In this sense my letters could be seen as an expression of an alloplastic fantasy motivated by my desire to change the environment just as the Unabomber sought to change society through his Manifesto. Did the therapist see these parallels?

Perhaps my identification with Thoreau and the Unabomber – two isolated writers with ambitious aims (in one case, the Unabomber, an individual who sought to radically alter society) points to an identifiable existential crisis or existential psychological struggle. I am reminded of the following passage from Erikson’s Young Man Luther – about religious reformer, Martin Luther, another isolated writer with grandiose aims:

“In the case of great young men (and in the cases of many vital young ones of whom we should not demand that they reveal at all costs the stigmata of greatness in order to justify confusion and conflict), rods which measure consistency, inner balance, or proficiency simply do not fit the relevant dimensions. On the contrary, a case could be made for the necessity for extraordinary conflicts, at times both felt and judged to be desperate. For if some youths did not feel estranged from the compromise patterns into which their societies have settled down, if some did not force themselves almost against their own wills to insist, at the price of isolation, on finding an original way of meeting our existential problems, societies would lose

Do Erikson’s observations about social isolation, (writing), and alloplastic fantasies have some general clinical applicability? Is Erikson talking about a recognized clinical entity?

It would be an exercise in grandiosity for me to compare myself with Martin Luther, but might there be something to be gained by looking at a commonality between Luther, the Unabomber, (to some extent Thoreau), and me? We trained in a profession and seemed destined for high achievements in that profession, experienced disillusion, and went off in another direction at a relatively advanced state of adulthood. Again, what are we talking about from a clinical psychiatric standpoint?

The following thoughts seem pertinent to the problem. First, there is a line of psychoanalytic thinking that links a motivation to “change the world” to object loss. “It is the grandiosity of the constituting idea formed in response to object loss that underpins the notion that words have the power to change the world. So, the idea that words have power, even magical power, is an aspect of the problem and not the solution. On a psychological level, the notion that words have power means that the individual’s words can lead to the return of the good object so all will be right with the world.” Levine, D.P. Psychoanalysis, Society, and the Inner World: Embedded Meaning
in Politics and Social Conflict. In my case, are alloplastic fantasies related to functional object loss in childhood?

Second, both Martin Luther and the Unabomber had childhoods marked by perceived object loss or aggression. Erikson notes that Luther, as a boy, was subject to severe disciplinary methods at the hands of his teachers. Instead of rebelling at the time Luther waited until he could explode with a vengeance [like the Unabomber?], doing so in a manner that permitted him to express his own mastery of the situation. Capps, D. Erik Erickson’s Verbal Portraits: Luther, Gandhi, Einstein, Jesus (2014). Other biographers note the issues of abuse and perceived mother-loss in Luther’s background. “Male melancholia, rooted in early childhood experiences of perceived mother-loss, is intrinsically linked to religiosity [or other dogmatic beliefs?]. Martin Luther suffered from melancholia that was related to, and exacerbated by, a corresponding obsessive-compulsive disorder. Luther’s melancholia appears to have been grounded in both childhood beatings (at least one of which was carried out by his mother) and his subsequent search for an identity. Luther’s melancholia also gave rise to life-long struggles with obsessive-compulsive anxieties. His religion, in which he believed he had discovered both an identity and a means for relief from his inner struggles, actually exacerbated his melancholia. He realized as an older man that religion had indeed become his substitute obsession and that a major part of his self had died.” Cole, Jr., A.H. “A Spirit in Need of Rest: Luther’s Melancholia, Obsessive-Compulsive Disorder, and Religiosity.” Pastoral Psychology, 48(3): 169-190 (2000). One wonders, in psychoanalysis have I discovered both an identity and a means for relief from my inner struggles?

In a court-ordered forensic examination the Unabomber attributed his lifelong inability to establish deep friendships, particularly with women, to “extreme psychological verbal abuse by his parents” while he was growing up. The examination report concluded that hypersensitivity and irrational rage at his family were symptoms of the Unabomber’s underlying mental illness. Marmion, S. “Unabomber’s Psychiatric Profile Reveals Gender-identity Struggle.” Chicago Tribune (1998).

My own psychological test report states: “Typically the parental expectations or rules were enforced quite literally, without consideration or flexibility regarding the needs and distresses of the child. Parental (or other family members’) tempers are apt to have been intensely threatening and frightening to the person as a small child. The parents were experienced as punitive and coercive of the child’s will and indifferent to the child’s distress, and punishments were often severe; many individuals with this profile were beaten with a strap as children.”]
That brings us back to my letters.

[Note my immediate association of my letters to the Unabomber Manifesto.]

A few years ago I did research on the Unabomber on the Internet and I came across results of his psychological testing.

[Note my obsessive research of people, my intense curiosity about people. This is a recurring theme in my therapy sessions. My curiosity about people parallels my intense introspection, my need for self-definition (a characteristic of the introjective personality), and my desire for psychoanalysis.]

It was his MMPI results. His complete MMPI results are on the Internet. Like me, his highest scales were paranoia and psychopathic deviate. I saw his paranoia score and my paranoia score on the MMPI was actually higher than the Unabomber’s. I’m actually crazier than the Unabomber. Another thing that fascinated me about the Unabomber case was the intensive FBI investigation.

[Note my dual identification. I identify with both the Unabomber (the guilty criminal) and his investigators (the FBI). Note the association to my love of the book Les Miserables about the criminal Jean Valjean and his pursuer, the police inspector Javert. Valjean, in the guise of his alias, Pere Madeleine, built a glass bead factory that employed thousands and transformed the region into a prosperous economic zone, reflecting an alloplastic fantasy, a desire to change the environment. The therapist would not have these associations, of course. But there is an association that an astute psychodynamic therapist might have relating to the criminal and his pursuer looking for clues as to the criminal’s identity. The astute therapist might associate to the dual roles of patient and psychoanalyst. The guilt ridden patient might be seen to symbolize the criminal Unabomber and the investigative FBI might be seen to symbolize the psychoanalyst, searching out clues as to the identity of his patient. When I talk about my dual identification of the Unabomber and the FBI am I not talking symbolically about my interest in the relationship between patient and psychoanalyst?]

I followed that closely in the 1990s, before they tracked him down. I was totally fascinated with the meticulous work the FBI did in hunting down clues about him, trying to find out his identity.

[Note my parallel fascination with the work of the meticulous psychoanalyst.]
That’s a funny thing about me. There are these dualities in my personality. I identify with both the Unabomber and the FBI investigators. On the Thematic Apperception Test they show you a picture of people in a fictional setting and you have to come up with a story about the picture. I took the Thematic Apperception Test, and I identified with all the people in the picture in different ways. Most people pick out a villain and a hero. They see the villain as bad and the hero as good. I’m not like that. I identify with everybody.

[I recall that back in the year 1998 I told Dr. Taub that I identified with Hitler. Dr. Taub looked at me like I was crazy. Dr. Taub asked me why I identified with Hitler and I said he was a victim of child abuse. I read that the Unabomber had been a victim of abuse and I recall being interested in that.]

There are all these fragments in my personality, so many different qualities fragmented in my personality. It’s as if I have a gallery of characters in my personality.

[When I talk about personality fragmentation am I referring to the ego defense of splitting and its possible relation to the childhood experience of trauma or abuse. Note that splitting and personality fragmentation are aspects of dissociation. So in this session we possibly see two different aspects of dissociation in me: mentally separating myself from my environment (as with my thoughts about Thoreau in his cabin) and the splitting of my personality into fragments (the gallery of characters). Does this letter itself – which reproduces my therapeutic narrative together with my later written commentary – not indicate a third aspect of dissociation: the splitting of the self into an experiencing ego and an observing ego? Did the therapist see that?]

Everybody I see is a fragment of my own personality. We talked about this before. I mentioned that I imagine at times that I am both the spectator at a performance and the actor on stage. So there are all these dualities in my personality.

[In his book Walden, Thoreau talked about himself metaphorically as a spectator at a theatrical performance. Thoreau wrote: “With thinking we may be beside ourselves in a sane sense. By a conscious effort of the mind we can stand aloof from actions and their consequences; and all things, good and bad, go by us like a torrent. We are not wholly involved in Nature. I may be either the driftwood in the stream, or Indra in the sky looking down on it. I may be affected by a theatrical exhibition; on the other hand, I may not be affected by an actual event which appears to concern me much more. I only know myself as a human entity; the scene, so to speak, of thoughts and affections; and am sensible of a certain doubleness by which I can stand as remote from myself as
from another. However intense my experience, I am conscious of the presence and
criticism of a part of me, which, as it were, is not a part of me, but spectator, sharing no
experience, but taking note of it; and that is no more I than it is you. When the play, it
may be the tragedy, of life is over, the spectator goes his way. It was a kind of fiction, a
work of the imagination only, so far as he was concerned. This doubleness may easily
make us poor neighbors and friends sometimes.”

[Thoreau seems to be describing dissociative states. Note how I do not simply
dissociate, but I identify with persons who dissociate, just as I do not simply
intellectualize, I identify with persons who intellectualize. I do not simply have certain
defenses; I identify with persons who have the same defenses. This may be more than
a psychological curiosity and may have significance as it relates to my difficulties in
group situations. The group theorist Elliott Jaques observed that groups and
institutions are used by their individual members to reinforce mechanisms of defense
against anxiety and in particular against recurrence of the early paranoid and
depressive anxieties first described by Melanie Klein. “On the Dynamics of Social
Structure: A Contribution to the Psychoanalytical Study of Social Phenomena Deriving
from the Views of Melanie Klein.” I am attracted to the idea that one of my difficulties
in group situations centers in some way, perhaps, on my inability to share mechanisms
of defense with the dominant defenses employed by most groups.]

THERAPIST: How do you feel about having these dualities in your personality?

PATIENT: I don’t know. It’s just who I am. I’m a person with dualities in my personality.

The therapist offered no interpretive comments. Nor did she make any interventions
that attempted to continue the narrative. The new material I presented at the session
did not contribute anything to the therapist’s past understanding of me. According to
Stanley Palombo the analyst’s (or therapist’s) perception of the patient must evolve,
incorporating new aspects of the patient’s personality that emerge in the wake of the
patient’s evolving narrative. Palombo, S. The Emergent Ego: Complexity and
Coevolution in the Psychoanalytic Process (Madison: International Universities Press,
1999).

Instead the session devolved into a discussion of my letter writing. The therapist fell
back on her usual cliches. She said, “You want to be an unforgettable patient.” She had
said this several times before. The comment was not related to the opening of the hour
and contributed nothing by way of interpretation. The therapist said, “You have a need
for attunement.” This is another one of the therapist’s cliches; she repeats this phrase
routinely. She gave me a lecture on the relationship of mother to child. “When the child feels that his needs are not being satisfied, it’s his perception that is important. Regardless of whether the child’s needs are being satisfied, if he feels that they are not being satisfied, this will have developmental consequences.”

In fact, that’s a problematic view of psychoanalytic thinking. Theorists across a spectrum of orientations emphasize actual empathic failure by the mother, and do not attribute pathogenicity to the child’s faulty registration of mother’s empathy. Self psychology (Kohut) avers that repeated empathic failures by the parents, coupled with the child’s responses to them are the basis of almost all psychopathology. (Note the therapist’s consistent omission of any consideration of the father’s role in the development of self, consistent with her failure to confront oedipal issues.) Mahler observed that failure of the mother to support empathically her child’s contrasting strivings for autonomy and fusion may lead to a collapse of the child’s omnipotence. Modell notes that the mother’s empathic failure at the time when the child is developing a sense of self propels him into a precocious and vulnerable sense of autonomy. (I had previously discussed with the therapist my pathological need for autonomy in both the mother-child and therapist-patient situations. I had even provided a copy of Modell’s paper on this very subject to the therapist!) Masterson and Rinsley attribute borderline disorder to a specific maternal failure of empathy: something they term depersonification. Campbell’s Psychiatric Dictionary at 332 (2009).

(The therapist majored in Gender and Women’s studies in college. Was her choice of college major related to a need to idealize women and mothers, a need to preserve an idealized image of her own mother – later expressed in the therapist’s need to attribute psychopathology to a child’s faulty registration of the good-enough mother as opposed to recognizing the effects of actual maternal failings?)

The therapist repeats the same ideas about the mother-child relationship at almost every session as though it were an idee fixe. Is the therapist’s formulation an expression of the therapist’s oral fixation? Is the therapist’s depiction of the mother-child relationship an expression of a Kleinian “bad mouth?” That is, the infant at the mother’s breast receives succor from the mother (the child sucks, he wants something from the mother) and the infant can bite the mother’s breast (he “acts out,” as it were). Is the therapist saying, “You wanted things from your mother (you wanted to suck), you perceived that you didn’t receive them and so you acted out (you bit her breast).” “You want things from me (you want to suck my breast) but you feel you don’t receive what you want, so you act out by writing letters (you bite your mother’s
breast). Is the therapist’s explanation for my letter writing actually a projection of the therapist’s oral-fixation and her oral sadism (a preoccupation with oral aggression, i.e., biting)? Does the therapist’s interest in sexual predators – her master’s thesis was on the subject of child sex molesters – actually (or ironically) relate to pregenital concerns rather than genital concerns? Note that the word predator can have oral connotations—the wild beast devours his prey. This is wild speculation, but at some level does the therapist view the erect penis as teeth that bite? (Note that the penis dentatus depicts the penis with teeth). According to Shengold, the teeth can represent the invading father and his penis. Shengold, L. Soul Murder: The Effects of Childhood Abuse and Deprivation at 101, 107, 115, 116 (New Haven: Yale University Press, 1989), “Both male and female children who have been overstimulated tend to see the adult penis as an organ that can effectively discharge cannibalistic overexcitation and can bite.” Id. at 107.

**ASSOCIATIONS TO THERAPIST’S ACT OF CONTEMPLATING NOT ACCEPTING MY LETTERS**

At one point in the session the therapist said, “I talked to my colleagues about your letter writing. They all told me I shouldn’t even accept your letters: that the letters place too much of a burden on my time.” I said, “Did you allow them to read the letters?” She said, “no, I just told them about your letter writing activity. I have decided to continue to accept your letters despite their advice.” Both the therapist and the persons she consulted emphasized the therapist’s burden without any consideration of my needs or best interests.

What was the therapist’s motive in telling me about this communication with third parties? Why didn’t she simply act or choose not to act without mentioning the outside communications?

**Association to Lack of Maternal Autonomy**

I have described growing up in a dysfunctional family in which my parents acquiesced in my aunt’s arrogation of a parental role. I previously wrote:

Patient grew up in a two-parent family with a six-years older sister. The family was dysfunctional in that in important but subtle ways the locus of power was not on the parents but in the mother’s older sister. The mother’s older sister was tyrannical; the parents were weak and dependent individuals with a poor level of autonomy. Both parents had never separated psychologically from their families of origin. This was
especially true of the mother who was profoundly dependent on her older sister for emotional support. In important ways the mother’s sister infantilized the mother. Both parents acquiesced in mother’s sister’s arrogation of a parental role. The mother’s sister was childless and married to a man who showed a reaction formation against aggression; he ceded marital power to his tyrannical wife.

My mother exhibited a significant lack of autonomy in her relationship with her older sister; my mother was highly dependent on her sister and relied heavily on her sister for advice and guidance. Frequently, my mother would seek out her sister’s advice on parenting issues. My aunt was quite forceful in her advice in how to deal with me. “You’re the mother. You need to show him who’s the boss.”

In the language of family theory, my mother showed a lack of autonomy in an enmeshed family system.

My therapist’s act of seeking guidance calls to mind my mother’s lack of autonomy and dependency. Is that simply my subjective impression, or is the therapist’s communication prototypical of a style of interacting with me that communicates the therapist’s lack of autonomy? Certainly, the therapist’s anaclitic (orally dominant) personality – and her lack of introjective development – is consistent with a lack of autonomy and dependency.

There may be a parallel also between a dysfunctional family system and the group dynamics of the clinic where I see the therapist (assuming the individuals with whom the therapist consulted were also affiliated with the clinic). It may be that the therapist’s decision to seek guidance from colleagues at the clinic and the colleagues’ act of giving advice about me were motivated by the group dynamics that are dominant at the clinic. In that case I could be seen as a pawn within a group dynamic, possibly a disturbed group dynamic, that is, the group dynamic prevailing at the clinic.

**Association to Workplace Difficulties**

My last employer terminated my employment in October 1991 days after I lodged a harassment complaint against my supervisor and coworkers. In a sworn statement the employer filed with the D.C. Department of Human Rights the employer justified the termination by stating that it had consulted with two mental health professionals, including a psychiatrist, who advised the employer that my harassment report was the product of paranoia and that in a situation such as mine, I should be terminated.
The employer wrote:

Because of the emotional and psychological nature of Mr. Freedman’s complaints and those lodged against him, Messrs. Lassman and Race also sought professional guidance from two outside consultants: (1) a representation from the Employee Assistance Program; and (2) a practicing psychiatrist. The two professionals advised that Claimant should seek counseling and did not oppose respondent’s recommendation to terminate Claimant. One of them identified Claimant’s habit of putting a negative meaning to virtually every event as “ideas of reference” and cautioned that individuals in similar circumstances may become violent.

After talking to Complainant and others, the undersigned and another lawyer (Malcolm Lassman, Managing Partner) decided to confirm the termination decision with outside professionals. Our law firm provides a service to all employees called Employee Assistance Program (“EAP”) for professional counseling services for those employees experiencing personal problems such as drug or alcohol abuse, emotional distress, depression, stress, family problems or other personal difficulties (see attached copies). Therefore we deemed it appropriate to discuss Complainant’s situation (anonymously) and our recommendation with this outside group. I do not have the identity of the counselor who spoke to us: however, as indicated earlier, she confirmed that removal from the work setting was the appropriate action to take. In addition, we spoke to Dr. Gertrude Ticho, a practicing psychiatrist in Washington, D.C. who is a personal friend of Mr. Lassman. By conference call, Mr. Lassman and I addressed our investigation findings (without identifying Complainant) as well as our proposed action. Dr. Ticho was very helpful and actually referred to Complainant’s habit of putting accusatory or bizarre meanings to trivial matters as “Ideas of Reference.” She felt the individual should be treated like any other employee and that if he was disruptive, the appropriate action to be taken would be to terminate his employment. She also cautioned that individuals with the characteristics we described could be prone to violence.

In fact, I was able to show by reference to persuasive documentary evidence that the employer’s sworn statement was perjured. Thus, the employer maintained – in the context of a pretextual perjured statement — that it had consulted two outside parties who advised the employer that I should be terminated.
I see parallels with the therapist’s act of going to two outside parties, who know nothing of my situation or the essentials of my therapy, and obtaining guidance that would support a decision to refuse to accept my letters. The parallels with my dysfunctional family – a situation where my parents were highly dependent on an outside party – are striking.

Again, was my therapist’s report of seeking guidance from outside parties on how to handle me a prototypical communication? Does the therapist routinely communicate in subtle or unconscious ways that she lacks autonomy and is dependent on outside parties as a feature of her anaclitic personality, i.e., her oral dependency?

**Association to Scapegoating**

In the therapist’s construction I am the active party placing a burden on her by giving her letters that I have written. My act of writing letters is not a legitimate need. I am the bad object, aggressing on the good therapist. In the therapist’s construction, she is being burdened and her legitimate time needs are being depleted. She is the good object, which is the target of aggression of the bad object, namely me. But what about the value that I am giving the therapist? Am I not providing the therapist valuable experience in working with a patient with severe introjective pathology? Am I not a learning tool for the therapist?

**The Therapist’s Apparent Lack of Professionalism**

The therapist fails to apply a learning model to her work with me. In general medicine a doctor relishes the opportunity to treat a rare disease. He learns from treating a disorder he rarely sees. I had an interesting experience with a past treating psychiatrist, Stanley R. Palombo, M.D. in 1993. I sought him out while I was in therapy at GW with Suzanne M. Pitts, M.D. I complained to Dr. Palombo about Dr. Pitts’ work with me. Dr. Palombo thought my complaint was paranoid but he said, “You can teach Dr. Pitts a lot about treating paranoia.” Dr. Palombo recognized that my character pathology offered a valuable opportunity for a psychiatrist to learn about paranoia; he depicted me as a learning tool and not as a burden. Dr. Palombo recognized that I had aspects of a good object and that I was not simply a depleting bad object. Notice that my current therapist does not say to herself, “This is a terrific opportunity for me to learn about introjective pathology.” No. She views treating me as a narcissistic injury and a burden. What does that say about her as a professional, i.e., her desire to grow as a professional? Compare: The therapist said, “A therapist’s expertise is not what’s
important in therapy. It’s the relationship between client and therapist that is important.” The therapist does not appear to have any interest in gaining knowledge.

**Association to Anal Defensiveness**

The therapist seems unconcerned with the content of my letters. She views the letters as a burden on her time. In effect, she has transformed the letter’s content into a quantity: the amount of time it takes her to read the letters. She has referred to the page length of the letters; she has referred to the number of issues I raise in the letters; she has twice talked about the amount of time it takes me to write the letters. She has never talked about the content of the letters or my affects associated with writing the letters.

Arguably, the act of converting a content into a quantity is an expression of anal defensiveness. In an earlier letter I had written about a former treating therapist, William D. Brown, Ph.D. I wrote:

Grunberger points out that the act of denuding an individual of personal characteristics, or personal identity, and substituting for that specific identity a numerical or quantitative designation, is an anally-determined procedure. See Grunberger at 381: “The anti-Semite’s specific [anal] regression is most clearly seen in his representation of the Jew [broadly speaking, a metaphor for the “bad child” imago]. This follows the line of destroying his individuality. The Jew is denuded of all personal characteristics[,] . . . in the concentration camps they were designated by numbers.” Cf. Shengold, L. Soul Murder at 152-153 (New Haven: Yale University Press, 1989): “‘Anal defensiveness’ involves a panoply of defenses evolved during the anal phase of psychic development that culminates with the individual’s power to reduce anything meaningful to ‘shit’—to the nominal, the degraded, the undifferentiated.”

The psychoanalyst Janine Chasseguet-Smirgel sees anal sadism as driving the need to see individuals (or any objects that have a specific identity) as indistinguishable from each other. In her essay “Perversion and Universal Law” Chasseguet-Smirgel refers to “an anal universe where all differences are abolished . . . All that is taboo, forbidden, or sacred is devoured by the digestive tract, an enormous grinding machine disintegrating the molecules of the mass thus obtained in order to reduce it to excrement.” In the anal universe Good and Evil are synonymous. The therapist seems to be saying, “All
your letters are identical and without meaning or content; they are simply written communications that take up time.”

There is an interesting parallel between the therapist’s defensiveness seen in her act of reducing my letters to the nominal and her use of clichés as pseudo-interventions (“You want to be an unforgettable patient;” “You have a need for attunement”); both the act of reducing the letters to a quantitative value (pieces of paper that take up temporal space) and her use of clichés are objectifications. The therapist’s use of clichés (an objectification) is a strong indication that her concerns about the letters taking up her time (another objectification) are purely rationalizations for sadistic maneuvers. Wurmser, L. Torment Me, But Don’t Abandon Me: Psychoanalysis of the Severe Neuroses in a New Key. “All rigidity and stereotypy in the [treatment] approach, everything that can be experienced as impersonal, general, nonindividual harbors the big danger that it is taken as a repetition of traumatic dehumanization and objectification.

**Associations to Issues of Depletion, Guilt and Fragility of the Therapist**

Modell described a kind of guilt based on the belief that taking is at someone else’s expense: “There is a common fantasy that is observed in psychoanalysis, that is: love is a concrete substance in limited supply within a given family—as if all of the family are obtaining nourishment from a closed container. The subsequent belief is: if one has something good, it is at the expense of someone else being deprived.”

This type of guilt, termed depletion guilt, is based on the belief that one’s own welfare is at the expense of another’s—that one is a survivor at someone else’s expense. It is a form of survivor guilt, which may take many forms, each related to a belief about the way in which the pursuit of normal developmental goals will harm significant others. Often parents contribute to these beliefs by conveying to their child, through praise or blame, an inaccurate sense of his or her ability to bring them happiness. These beliefs are encouraged by parents who convey to their children an inaccurate sense of their ability to affect the quality of their parents’ lives. Some parents convey a sense of fragility which the child perceives unconsciously. Some individuals are burdened by unconscious guilt over hurting somewhat fragile mothers by depleting them. Friedman, M. “Survivor Guilt in the Pathogenesis of Anorexia Nervosa.” Psychiatry, 48: 25-39 (February 1985).

Is the therapist’s message to me that I am burdening her time, depleting her of available time, a prototypical communication – an example of a style of subtle or
unconscious communication that I am depleting her, that she is fragile, or that I am damaging her? Does the therapist have a style of communicating that tends to aggravate rather than lessen my possible struggle with unconscious guilt?

Returning to the material concerning my therapeutic narrative that opened this letter one wonders whether the ascetic or monastic lifestyle that both Henry David Thoreau and the Unabomber pursued was motivated by a struggle centering on unconscious guilt. In Karl Menninger’s *Man Against Himself*, the author identifies four dimensions of asceticism (and martyrdom)—i.e., aggression, a desire to be punished (guilt), an erotic motivation and a self-destructive impulse—and then proceeds to demonstrate the presence of these features in both clinical cases of neurosis and psychosis as well as in examples taken from history of religious ascetics and martyrs. Is there a tie-in with Martin Luther? Luther railed against the corrupt medieval practice of Papal indulgences—a pay-to-play system in which the parishioner obtained absolution from sin (guilt) in return for the transfer of money to the church.

The Sanskrit scholar and psychoanalyst Jeffrey Masson views asceticism, or instinctual renunciation, as a form of depression in which aggression is turned against the self. (Freud viewed the psychological state of unconscious guilt as derived from the same motivations. Thus, for example, in Moses and Monotheism, Freud writes: “[T]he need for satisfying [a] feeling of guilt, which coming from a much deeper source was insatiable, made [the Jews] render their religious precepts ever and ever more strict, more exacting, but also more petty. In a new transport of moral asceticism the Jews imposed on themselves increasing instinctual renunciation, and thereby reached at least in doctrine and precepts ethical heights that had remained inaccessible to the other peoples of antiquity.”)

“The [Indian] ascetic pursues a deathless state in which his fierce and violent disciplines are designed to move him beyond the normal limits of pain, physical discomfort, and mortality. In the Indian tradition, the human condition inevitably entails pain and suffering. What distinguishes the deities is the fact that they do not suffer. In torturing his body, and learning to endure pain, the pain is transformed. It becomes the very means to conquer suffering. It becomes the source of masochistic pleasure as the ascetic demonstrates to himself and to others that he is well on his way to achieving immunity from the human categories of pain, suffering and [–like Thoreau and the Unabomber in their respective cabins in the woods–] vulnerability to the elements.” Kumar, P.P., Contemporary Hinduism. This passage about Hindu asceticism has striking parallels to the psychology of the anorexic who achieves some form of contentment in the experience of starvation.

**Law Enforcement Concerns and the Therapist’s Possible Breach of Ethical and Legal Duties**

As recently as July 27, 2017 I was subject to a civil protection order imposed by D.C. Superior Court on the petition of my primary care doctor who alleged that he feared for his personal safety because of my writings about him on social media. From July 2016 to July 2017 I reported regularly to a court-appointed probation officer. Under the terms of the one-year protection order I am barred from purchasing a gun for five years (until July 2021).

The DC Government earlier determined that at my former place of employment my employer had reasonable concerns, based on a psychiatrist’s opinion, that I might become violent; that my coworkers had formed genuine and credible fears that I might become armed and extremely dangerous; and acquiesced in a finding by my former direct supervisor that I might have had plans to burglarize the premises of my former employer and either murder my supervisor or carry out a mass homicidal assault on the premises.

Dimitrios Georgopoulos, M.D. diagnosed me with paranoid schizophrenia in 1996. Albert H. Taub, M.D. (St. Elizabeths Hospital and DBH) diagnosed me with paranoid schizophrenia in 1999 and cited my “prolific letter writing” as an aspect of my illness. Arguably, the therapist has an ethical and legal duty to review my writings. Cf. Tarasoff v. Regents of the University of California, 551 P.2d 334 (Cal. 1976). Her failure to do so, in a situation in which I might carry out a crime of violence (including, according to DC Government findings, murder or mass homicidal assault), might expose her to legal jeopardy.

Let me pose the following hypothetical:

A patient writes letters to his therapist that she refuses to accept. In fact the letters, which are addressed to the therapist, contain descriptions of disturbing and violent fantasies. Because the therapist does not accept the letters she never learns about the patient’s disturbed fantasies. The patient murders someone. The police discover the
letters addressed to the therapist. The police read the letters and learn of the individual’s (secret) disturbed fantasies. The police go back to the therapist. “Did you read his letters? She says, “no. I was concerned that reading the letters might burden my time.” The police will ask the therapist: “Do you realize you could have prevented a murder if you had read the letters?” — Can you imagine the therapist being cross-examined by the prosecutor at trial?

Question: May a therapist refuse to read letters written by her patient in a situation where the patient has been diagnosed with paranoid schizophrenia (psychotic mental illness), where similar past letters were adjudged by a DBH psychiatrist to be a symptom of paranoid schizophrenia, where the patient was determined by the D.C. Government to be possibly armed and extremely dangerous, and where the patient was adjudged by his primary care physician to pose a danger to the doctor on the basis of the patient’s past writings, and where the patient, as recently as a month ago, was on supervised probation by the DC Government as part of a state court order that mandated mental health treatment?

[I was a victim of workplace mobbing during my employment at the law firm of Akin Gump Strauss Hauer & Feld. A recognized feature of mobbing is that coworkers spread rumors that the targeted employee is violent (and in my case, homicidal). In mobbing, the employer sometimes colludes with the mobbers against the targeted employee (which happened to me). I am not a violent person, but the District’s findings are what they are.]

January 12, 2016
3801 Connecticut Avenue, NW
Apartment 136
Washington, DC  20008

Tanya A. Royster, M.D.
Director
D.C. Department of Behavioral Health
64 New York Avenue, NE
Third Floor
Washington, DC  20002

Dear Dr. Royster:
I am a consumer of mental health services provided by the D.C. Department of Behavioral Health (DBH). I receive supportive psychotherapy and medical management provided by Alice E. Stone, M.D., a third year psychiatry resident at 35 K Street. Dr. Stone works under the supervision of Earle Baughman, M.D. (St. Elisabeths Hospital).

I am deeply concerned about the failure of DBH to provide appropriate psychotherapy for me, which would be psychodynamic, insight oriented therapy. Supportive psychotherapy is inadequate for my needs.

I need to remind the DBH that the D.C. Office of Attorney General and others have grave concerns about my case and my potential for violence, including the potential for armed mass homicide.

1. The D.C. Office of Attorney General affirmed as genuine and credible a psychiatric opinion offered to my former employer, Akin Gump Strauss Hauer & Feld (Dennis M. Race, Esq.) (1991) that concluded that I suffered from severe mental illness that rendered me unsuitable for employment and a direct threat in the workplace. The employer in a sworn statement stated that it feared, based on said psychiatric opinion, that allowing me to remain on the firm’s premises posed a negligence risk to the firm. (The psychiatrist in question, Gertrude R. Ticho, M.D. (deceased) denied ever having offered said opinion to the employer. See letter to William J. Earl, Esq. dated March 19, 1996 (enclosed)).

2. The D.C. Court of Appeals did not find that my former supervisor’s published fear (1991) that I might commit a mass homicidal assault on the firm’s premises and her act of securing her office against such an assault was motivated by discriminatory animus. See Record at 41, Freedman v. D.C. Dept. Human Rights, D.C.C.A. no. 96-CV-961 (Sept. 1, 1998).

3. The D.C. Office of Attorney General found that my coworkers’ fears that I might become armed and extremely dangerous in August 1989 (two years before my job termination) were genuine and credible. The AG concluded that my coworkers had genuine and credible fears that I might “buy a gun, bring it in, and shoot everybody.” See Brief of D.C. Office of Corporation Counsel at 8 citing Record at 276, Freedman v. D.C. Dept. Human Rights, D.C.C.A. no. 96-CV-961 (Sept. 1, 1998).

4. On October 12, 2004 the MPDC dispatched 10 police officers and four FBI agents to my residence to escort me to D.C. General Hospital for an emergency forensic
psychiatric examination. The MPDC feared that I might become armed and extremely
dangerous.

I urge the DBH to heed the concerns of the D.C. Attorney General and the MPDC and
provide the psychodynamic psychotherapy that I require.

Thank you.

Sincerely,

Gary Freedman
THERAPY SUMMARY – SEPTEMBER 11, 2017

THERAPIST: Would you like something to drink? Coffee, tea?

PATIENT: No, thank you. You know, I am going to show off.

THERAPIST: You’re going to show off.

PATIENT: Yes. You know, I can remember the last time a therapist offered me something at the beginning of a session. It was May 13, 1991. It was my first session with Dr. Sack. He was a big-time psychiatrist/psychoanalyst. He had two degrees from Harvard. I once saw him on TV testifying before Congress on some mental health issue. He was the past president of the Washington Psychiatric Society. His office was in my building. That would have been convenient for me to see him. I stopped seeing him after three sessions.

THERAPIST: Why did you stop seeing him?

PATIENT: I thought he was in communication with my employer. Anyway, I still remember that. The reason I can remember that is that May 13 was the anniversary of Sigmund Freud’s circumcision. I don’t think it was appropriate for him to offer me something to drink.

THERAPIST: How do you feel about me offering you something to drink?

PATIENT: You’re not a psychoanalyst so I don’t care. A psychoanalyst shouldn’t offer things to a patient. But you’re not a psychoanalyst. . . . Last time we talked about the fact that you had spoken to people about my letters. You said they advised you not to accept my letters. You know, I was thinking that maybe you have a legal duty to accept my letters. I worked up something in my letter this week about that. Let me read you what I wrote:
Question: May a therapist refuse to read letters written by her patient in a situation where the patient has been diagnosed with paranoid schizophrenia (psychotic mental illness), where similar past letters were adjudged by a DBH psychiatrist to be a symptom of paranoid schizophrenia, where the patient was determined by the D.C. Government to be possibly armed and extremely dangerous, and where the patient was adjudged by his primary care physician to pose a danger to the doctor on the basis of the patient’s past writings, and where the patient, as recently as a month ago, was on supervised probation by the DC Government as part of a state court order that mandated mental health treatment?

And then I pose the following hypothetical:

A patient writes letters to his therapist that she refuses to accept. In fact the letters, which are addressed to the therapist, contain descriptions of disturbing and violent fantasies. Because the therapist does not accept the letters she never learns about the patient’s disturbed fantasies. The patient murders someone. The police discover the letters addressed to the therapist. The police read the letters and learn of the individual’s (secret) disturbed fantasies. The police go back to the therapist. “Did you read his letters? She says, “no. I was concerned that reading the letters might burden my time.” The police will ask the therapist: “Do you realize you could have prevented a murder if you had read the letters?” — Can you imagine the therapist being cross-examined by the prosecutor at trial?

So, I think you might have a legal duty to read my letters.

THERAPIST: I am going to say something. You might not want to hear it. That letter could be used as evidence to have you committed. I need to caution you about sending that letter out to people. I know you don’t pose a danger. I don’t see that letter as threatening. I wouldn’t have you committed. But if you were to show that to another therapist, he might think that you posed a danger and might initiate a commitment. I felt I need to caution you about that.

PATIENT: I seriously doubt the letter could be used to have me committed. Does this letter contain a threat? It doesn’t threaten anybody. I’ve written far more provocative things than this and they didn’t have me committed.

Let me read from I something I included in my letter this week. This is from a letter I sent to DBH in January 2016:
On October 12, 2004 the MPDC dispatched 10 police officers and four FBI agents to my residence to escort me to D.C. General Hospital for an emergency forensic psychiatric examination. The MPDC feared that I might become armed and extremely dangerous.

[The therapist does not inquire into concerns voiced by others that I was a violent person, even homicidal. She doesn’t seem to have any curiosity about why persons would allege that they feared I might be a homicidal maniac. I found that odd.]

* * * *

PATIENT: I want to talk about something that I discuss in my letter. I wonder if you convey to me in some way that you are a fragile person. I mean, last week you said that my letters were a burden on your time. You talked to people about that – the idea that I was imposing a burden on your time. And I wonder if that was some kind of prototypical message – that maybe in the past you have communicated in subtle or unconscious ways that you are a fragile person. What I write about in the letter is that that’s related to problems in my family when I was growing up. My aunt – my mother’s sister – was always communicating to me that I needed to help my mother. That I had a responsibility to make her life better. She did some really strange things, said some really strange things to me over the years.

I remember when I was 12 years old, I was home. It was summer time. So I was home from school. And one afternoon, she came to visit when nobody else was home. I was home alone. She took me upstairs to the bathroom and had me help her clean the bathroom. She never did things like that with my sister. I think my aunt idealized my sister. But with me, she seemed to project a debased image onto me. It was as if I was her bad self and my sister was her good self. She had that split in her thinking. I had a responsibility to be my mother’s caretaker. My sister was not assigned that role.

I remember the day my sister got married in 1969. I was 15 years old. My sister and her new husband were going to Miami on their honeymoon. And my aunt said to me: “Wouldn’t it be nice if you got a job, Gary, saved up your money and took your mother on a vacation to Miami some day?” My aunt was saying that I had this duty to make my mother’s life better. My sister never had that duty. My aunt idealized my sister.

THERAPIST: Your aunt wanted you to take your mother to Miami. Where was your father in all of this. Your aunt seems to treat your father as if he didn’t exist. What was the relationship like between your aunt and your father?
PATIENT: The relationship between them was cordial and polite on the surface. But I think my father was afraid of my aunt. And my aunt held my father in contempt. I think she thought he wasn’t an adequate provider. My father worked in a factory. My aunt’s husband was a commercial artist. They had a house in the suburbs, and combined with the fact that they had no children, they had money. Also, I think there may have been an issue of antisemitism. My aunt was Polish Catholic and my father was Jewish. It’s as if my aunt had two compartments in her mind. In one compartment was me and my father, it was the debased compartment. In the other compartment was my mother and my sister, it was the idealized compartment. I think it was gender based.

When I was four years old [in the session I mistakenly said “when I was 6 years old”], it was my sister’s 11th birthday.

[My sister’s birthday is September 17. The current therapy session (September 11) took place days before my sister’s birthday. The issue of Freud’s birthday implicitly arose at the beginning of the session with my reference to Freud’s circumcision, which according to Jewish tradition took place on the eighth day after Freud’s birthday on May 6.]

What my aunt did is she went to a department store and purchased a piano and had it sent to your house. She made the first payment and my parents were supposed to make the remaining payments. Well, my father couldn’t afford a piano. My mother had to contact the department store and have them take the piano back. My aunt wanted my sister to learn to play the piano. That was my aunt’s idealized self. In fact, later, my aunt purchased her own electric organ and started taking organ lessons, so playing a keyboard instrument was something my aunt wanted for herself.

THERAPIST: In your aunt’s mind, you sister was the little girl she never got to be.

PATIENT: Exactly! Exactly! My aunt had this bad childhood. Her father died when she was 5 years old. My mother was 3 years old. And their mother – my grandmother – was an incompetent woman who could barely speak English. So from the age of 5 there was this severe role reversal in my aunt’s family. She had to take on the burden of being the mother in the family. And my aunt projected that role on to me. Apparently, my aunt viewed that as a debased role.

[The name of my aunt’s and mother’s father, Stanley – my grandfather — was the same as a former idealized psychiatrist of mine, Stanley R. Palombo, M.D. My maternal grandfather died in the great influenza epidemic of 1918. My paternal grandfather died]
in 1929 of meningitis. Both grandfathers thus succumbed to infectious diseases. The theme of infectious diseases, such as the HIV infection, is prominent in my writings as a literary device. My father used to say on occasion, “If my father were alive today they could have treated his meningitis.” An important aspect of my thinking is “with the right therapist I could be cured.” That is, “in another time, in another place” things would have been different. That is an example of the ego defense of dissociation, so prominent in my thinking. The theme of infectious diseases emerges in the dream interpretation attached as an appendix to this letter. The dream sheds light on my motivation in my writing letters to my therapist, namely, my split or complementary image of myself as both patient and doctor treating that patient’s illness, a dissociated image.

THERAPIST: The parentified child.

PATIENT: Yes, the parentified child. My aunt was a parentified child and she projected that on to me. That was the bad self role. And my sister was the good self, the idealized self that my aunt didn’t get to be as a child because she had an incompetent mother.

[It is possible also that my aunt’s compulsive solicitude toward my mother was a reaction formation against unconscious feelings of hatred toward her younger, envied sister. Thus, in my aunt’s mind I was not only a projection of the parentified child but also a personification of the younger, envied sibling. Such a reaction formation would account for my aunt’s “guard dog” attitude toward my mother; my aunt was always on the lookout for the slightest sign that my mother was being aggressed upon by others. In a dysfunctional family “the guard dog” is a family member who blindly attacks family members perceived as causing the slightest upset to their esteemed spouse, partner, or child – or sister.]

Anyway, they had to take the piano away. My sister maintains as an adult that the whole piano thing was my aunt’s attempt to humiliate my father. My sister says my aunt had to have known that my father couldn’t afford a piano and piano lessons and that she had to have known the piano would have to be taken back. Anyway, that’s all I remember from the incident – the confusion I felt. I was 4 years old. When they came to take the piano away all I remember is that my mother was crying when the movers came. I didn’t understand what was happening. I remember being confused. And I asked my mother what was happening, and she said, “We can’t make the monthly payments.” Well, I was only 4 years old, and I had no idea what she meant by that. How is a four year old kid supposed to know what monthly payments are? So I remember having all this confusion, and my mother’s explanation only confusing me more.
THERAPIST: Perhaps you felt that you were being punished.

[Note that at the beginning of the hour the therapist on her own initiative talked about my being punished (committed) in response to my letter which referred to violence. Was the therapist’s reference to punishment in the current context a projection of the therapist’s own concerns about punishment?]

PATIENT: Not that I remember. All I remember is all the feelings of confusion. And then my mother’s explanation which only made me more confused. All I remember is the feelings of confusion.

DISCUSSION:

The overarching issue of the session in my opinion was aggressive impulses – intrapsychic aggressive impulses, the vicissitudes of aggressive impulses, and the playing out of aggressive impulses in the interpersonal field.

1. Projection of Aggressive Impulses By Group Members under the Pressure of Group Life

I had severe interpersonal problems at my last place of employment. I was apparently a victim of workplace mobbing, an often subtle form of emotional abuse in the workplace, involving “ganging up” by co-workers, subordinates or superiors, to force someone out of the workplace through rumor, innuendo, intimidation, humiliation, discrediting, and isolation or shunning. My coworkers spread a rumor that I was homosexual. Rumors that I was potentially violent and even homicidal emerged at times during my three-and-one-half year tenure.

From the perspective of group theory it appears that staff comprised a paranoid fight-flight basic assumptions group that featured a high level of group cohesion and the projection of aggressive impulses (and, at times, libidinal impulses) onto scapegoats and outsiders. According to group theorist and psychoanalyst Wilfred Bion, in the basic assumption of fight-flight, the group behaves as though it has met to preserve itself at all costs, and that this can only be done by running away from someone or fighting someone or something. In fight, the group may be characterized by aggressiveness and hostility (against a scapegoat or outsider); in flight, the group may chit-chat, tell stories, arrive late or any other activities that serve to avoid addressing the task at hand. The leader for this sort of group is one who can mobilize the group for attack, or lead it in flight.
A fight-flight basic assumptions group is a type of paranoid group formation in which the group splits good from bad and proceeds to idealize the group-as-a-whole (“the good”) and projects the bad onto a scapegoat in the group or an external enemy. I worked as a paralegal at a law firm. A law firm is well suited to fight-flight phenomena since the rational work task of representing clients against the opposing party can assume a paranoid fight-flight posture of projecting the primitive proto-mental states surrounding the good object onto the client and projecting primitive proto-mental states surrounding the bad object onto the opposing party – as well as onto a scapegoat on the law firm staff.

The group theorist and psychoanalyst Elliott Jaques pointed out that persons struggling with unconscious guilt are well suited to taking on the scapegoat role in a disturbed group. The individual’s personal need for punishment (guilt) may attract aggression by members of a paranoid fight-flight group that is bent on projecting warded off aggressive (and libidinal) impulses emanating from the group-as-a-whole against a scapegoat.

I suffer from severe introjective pathology that centers on issues of guilt, a need of self-definition and autonomy. These qualities impair my integration into a type of group that places a high premium on homogenization and the suppression of personal identity.

In a paranoid fight-flight group I may be at high risk of assignment by the group-as-a-whole to an outsider or scapegoat role. I am thus at high risk of being subjected to the warded off aggressive (and libidinal) impulses of the group.

It is through the mechanism of projective identification that one member of a group on behalf of the other members, can come to serve as a kind of “sponge” for all the anger or all the depression or all the guilt in the group. The group may then launch the angry member and management, or a depressed member may be unconsciously maneuvered into breaking down and leaving the organization. This individual not only expresses or carries something for the group (warded off aggressive and libidinal impulses), but also may be used to export something that the rest of the group then need not feel in themselves. Hendrikz, D. “Group Dynamics – Behavioral Dynamics of Groups.” (1999).

The following excerpts from the therapy narrative may grow out of the above disturbed group dynamics.
Question: May a therapist refuse to read letters written by her patient in a situation . . . where the patient was determined by the D.C. Government to be possibly armed and extremely dangerous.[]

On October 12, 2004 the MPDC dispatched 10 police officers and four FBI agents to my residence to escort me to D.C. General Hospital for an emergency forensic psychiatric examination. The MPDC feared that I might become armed and extremely dangerous.

2. Internalization of Aggressive Impulses in a Dysfunctional Developmental Environment Resulting in Pathological Structuralization

Freud proposed that when the superego is set up it is endowed with that part of the child’s aggressiveness which, because of his love for them, he cannot direct against the parents, who frustrate his instinctual wishes. The internalized parents become the superego, but the severity of the superego corresponds not with the severity of the parents, but with the amount of the child’s aggressiveness towards them, now taken into the superego. The identifications and introjections occurring in superego formation involve an instinctual defusion, so that the released destructive impulses add to the severity of the superego. van der Dennen, J.M.G. “Psychoanalytic Theories of Aggression.”

But the child’s aggressive drive is not an essential, ongoing source of bad feelings. The presence of a hated and hateful object within the psyche will be a chronic source of anger, self-hatred and guilt. A child who, through a combination of constitutional endowment and bad experiences with caretakers, elaborates for himself a hated and hateful world has in a very literal sense recruited a large part of the interpersonal world into his affective states and encapsulated it in bad object representations, which then constantly generate anxiety, depression, emptiness, guilt, pain and other bad feelings. Spezzano, C. “Affect in Psychoanalysis: A Clinical Synthesis.”

I grew up in a disturbed, dysfunctional family in which my assigned scapegoat role both mediated my instinctual endowment, my drives, and served as the source of an internalized moral authority capable of meting out punishment.

My therapeutic narrative highlights different aspects of pathogenic family interactions:

I think my aunt idealized my sister. But with me, she seemed to project a debased image on to me. It was as if I was her bad self and my sister was her good self. She had that split in her thinking.
It’s as if my aunt had two compartments in her mind. In one compartment was me and my father, it was the debased compartment. In the other compartment was my mother and my sister, it was the idealized compartment. I think it was gender based.

My aunt was a parentified child and she projected that on to me. That was the bad self role. And my sister was the good self, the idealized self that my aunt didn’t get to be as a child because she had an incompetent mother.

What I didn’t point out in the session was that the split in my aunt’s thinking was syntonic with the belief system of the family-as-a-whole. In effect, my family served as an adaptive niche for my aunt’s splitting — a family that supported and maintained the splitting seen in all the family members which ultimately supported and preserved my scapegoat role.

Everett and Volgy found that in some dysfunctional families the most striking feature is that the mechanisms of splitting and projective identification are not displayed simply by an individual but pervade the parent-child subsystem. Splitting occurs when positive and negative feelings and thoughts are separated and experienced by family members in isolation of one another. This splitting distorts the family’s perception of reality in such a way as to cause them to experience both internal or external events or issues as either “right” or “wrong,” “black” or “white.” Such rigidly split perceptions occur without regard to the complexity of situations, roles or relationships. Studies of dysfunctional families identified a similar pattern where within the family system “positive attributes of ‘goodness’ and negative attributes of ‘badness’ were separated and reinvested such that each family member appears relatively preambivalent and single-minded in relation to the child.” This splitting appears to protect the system from potential feelings of loss and disappointment as well as from the negative affects of anger and hostility.

The projective identification process within a system operates in concert with that of splitting to form rigid role assignments and expectations among specific family members. In the dysfunctional family, the threat of conflict or aggression in the marriage, which would also threaten the survival of the system, is projected onto a child who “owns” the projection and behaves more aggressively while returning the spousal subsystem to a calmer level.

In assessing a clinical family, most family therapists would identify a central triangle, typically between parents and a child, which serves to balance the entire system. The role of the triangulated child is often defined by either parentification or scapegoating.
Everett and Volgy identified in the dysfunctional family predictable patterns of two central triangles and termed these coexisting triangles. It appears that the unique level of emotional intensity in the dysfunctional family requires multiple central triangles to balance and stabilize the system. They typically take the form of split and projected images of a triangulated “good” child and “bad” child. It appears that the tenuousness of the parental bonding and the continual threat of destructive anger requires two children to perform these specified roles in order to dissipate these threats and to ensure the survival of the system. “Borderline Disorders: Family Assessment and Treatment.” in Chronic Disorders and the Family, Walsh, F and Anderson, C.M., eds. (1988).

Everett and Volgy emphasize the role of projection and projective identification in the dysfunctional family that relies on scapegoating. Novick and Kelly found that children who are the objects of projection are subject to intense anxiety and guilt in relation to drive expression. The drives are constantly reinforced by the parental projections, and the development of an autonomous and adaptive defense system is hindered. A brittle superstructure, based on an identification with the primitive superego and defense system of the projecting mother, is created. “Projection and Externalization.” The Psychoanalytic Study of the Child, vol. 25: 69-95 (1970).


My aunt was also the prime spokesman and promoter of the view that I owed a duty to improve my mother’s life, as seen in the following passages in the therapeutic narrative:

My aunt – my mother’s sister – was always communicating to me that I needed to help my mother. That I had a responsibility to make her life better.

My aunt was saying that I had this duty to make my mother’s life better. My sister never had that duty. My aunt idealized my sister.

My aunt had this bad childhood. Her father died when she was 5 years old. My mother was 3 years old. And their mother – my grandmother – was an incompetent woman who could barely speak English. So from the age of 5 there was this severe role reversal in my aunt’s family. She had to take on the burden of being the mother in the family.
And my aunt projected that role onto me. Apparently, my aunt viewed that as a debased role.

Friedman found that parents can contribute to guilt in a child by conveying to the child, through praise or blame, an inaccurate sense of his or her ability to bring them pleasure or pain. Guilt is encouraged by parents who convey to their children an inaccurate sense of their ability to affect the quality of their parents’ lives. These communications may be subsumed in a family belief system that holds that love is a concrete substance in limited supply within a given family – as if all of the family are obtaining nourishment from a closed container. The subsequent belief is: if one has something good, it is at the expense of someone else being deprived. Friedman terms the type of guilt engendered by such a belief system depletion guilt (a form of survivor guilt), which is the belief that one’s own welfare is at the expense of another’s – that one is a survivor at someone else’s expense. Survivor guilt may take many forms, each related to a belief about the way in which pursuit of normal developmental goals will harm significant others. “Survivor Guilt in the Pathogenesis of Anorexia Nervosa.” Psychiatry, 48: 25-39 (1985).

The various disturbed communications in my dysfunctional family, in which I was assigned a scapegoat role, promoted severe introjective pathology which features instinctual renunciation (Friedman), guilt (Friedman and Blatt), depression (Spezzano and Blatt), dissociated lack of awareness of needs (Friedman), and intense anxiety and guilt in relation to drive expression (Novick and Kelly). My experience in a developmental environment in which important others were controlling, overly-critical, punitive, judgmental, and intrusive promoted pathologically introjective concerns for autonomy, self-definition, an over-ideational adaptation as well as depressive states around feelings of failure and guilt centered on self-worth (Blatt).

In the group context my pathologically introjective personality places me at high risk of scapegoating (see section 1, above).

3. Displacement of Aggressive Impulses by the Therapist

Let us recall the following excerpt from the therapy narrative:

THERAPIST: I am going to say something. You might not want to hear it. That letter could be used as evidence to have you committed. I need to caution you about sending that letter out to people. I know you don’t pose a danger. I don’t see that letter as threatening. I wouldn’t have you committed. But if you were to show that to another
therapist, he might think that you posed a danger and might initiate a commitment. I felt I need to caution you about that.

As in past sessions the therapist displaces her aggressive feelings against me onto my relations with third parties.

Displacement – together with denial and repression – is a characteristic ego defense of anaclitic personalities. I view the therapist as having an anaclitic personality with poor introjective development.

Past instances of the therapist’s displacement are the following:

When I criticize past therapists the therapist says, “People who idealize some people devalue others.” Translation: “I feel that you devalue me.”

When I talk about a previous psychiatrist who bragged about his job interview she says, “People seem to feel they need to prove themselves around you.” Translation: “I feel I need to prove myself around you.”

When I talk about my sister’s emotional vulnerability, the therapist mildly chastises me, “I get the feeling that you are judging your sister.” Translation: “I feel that you judge me.”

When I say that I loved my sister more than my mother, the therapist says, “You were trying to provoke your mother.” Translation: “I feel you are trying to provoke me with your letters.”

In the current session the therapist states:

You write about violence. I wouldn’t have you committed but another therapist might use your letter as evidence that you require commitment. Translation: I have aggressive feelings against you and I feel that you need to be punished.

Support for my interpretation comes from an interaction that I had in 1996 with a previous treating psychiatrist, Dimitrios Georgopoulos, MD at GW. I had been writing letters about Dr. Georgopoulos’ work with me on a regular basis. By early 1996 I had a sizable collection of letters that I sent to one of the trustees of George Washington University (Harold Baker, Esq.). Dr. Georgopoulos said to me: “We received a call from one of the university trustees. He said you sent him a collection of letters. I need to
4. Neutralization of Aggressive Impulses in the Oedipal Situation – Opportunistic Leveraging of Aggressive Impulses — Narcissistic Disturbance

Let us turn to the following portion of the therapeutic narrative:

When I was four years old, it was my sister’s 11th birthday. What my aunt did is she went to a department store and purchased a piano and had it sent to your house. She made the first payment and my parents were supposed to make the remaining payments. Well, my father couldn’t afford a piano. My mother had to contact the department store and have them take the piano back. My aunt wanted my sister to learn to play the piano. That was my aunt’s idealized self. In fact, later, my aunt purchased her own electric organ and started taking organ lessons, so playing a keyboard instrument was something my aunt wanted for herself.

Anyway, they had to take the piano away. My sister maintains as an adult that the whole piano thing was my aunt’s attempt to humiliate my father. My sister says my aunt had to have known that my father couldn’t afford a piano and piano lessons and that she had to have known the piano would have to be taken back. Anyway, that’s all I remember from the incident – the confusion I felt.

It may be important to emphasize that the incident occurred when I was four years old, at the height of my Oedipal struggles. Can Oedipal dynamics be imposed on this fact situation? Keep in mind that my father used to beat me as a child. That fact, combined with my own Oedipal strivings may have conspired to create in my mind an image of my father that was quite frightening. The above incident highlights the power of my aunt in the family system, including, at least in my sister’s opinion, the power to humiliate my father. Did I use my aunt psychologically to neutralize the power of the Oedipus complex by denial and debasement of my father? The following observations concerning the role of grandparents in the oedipal situation seem pertinent:

In 1913, Karl Abraham went on to discuss his clinical impression that a patient who emphasized grandparents had violently rejected a father or mother. He pointed out that a child may play grandparents against parents to get even with parents and that
children take the word “grand” at face value, literally “grander than parents.” He described brief clinical vignettes to illustrate, in one case, idealizing grandfather as more powerful than father and, in another, displacing anger from mother onto grandmother. Finally, he concluded, as Jones did, that grandparents are used to neutralize the power of the Oedipus complex by denial and debasement of the original parent figures, that is, a variation of the “family romance.” Tucker, L., Jr. “The Grandparent Syndrome: A Case Study.” Landrum Tucker, Jr. The Psychoanalytic Study of the Child, vol. 61: 82-98 (2006).

In some sense I may have used my aunt opportunistically as a self-protective measure to neutralize my fears about my father’s power in the Oedipal situation.

I have a remote association to issues from my adult life including the matter that opened this therapeutic session, my act of seeming to impose a duty on my therapist to read my letters. Recall that at the beginning of the session, I stated the following:

You said they advised you not to accept my letters. You know, I was thinking that maybe you have a legal duty to accept my letters. I worked up something in my letter this week about that.

I then went on to discuss defamatory accusations made against me at my last place of employment to the effect that I might be violent, even homicidal.

In my life I have shown a propensity to use aggression directed against me in an opportunistic way. I repeatedly try to leverage other people’s aggression to satisfy my own aims. For example, my former employer filed a perjured sworn statement with a state human rights agency alleging that it had determined that I had severe mental illness and that I might become violent. I used the employer’s aggression against me, that is, the employer’s defamatory statements about me, opportunistically to obtain Social Security disability benefits. I proceeded to file the employer’s defamatory sworn statement with SSA in my petition for disability benefits – so I used that defamation to file for disability benefits. (Note the fact that SSA disability benefits are paid monthly. They are monthly payments. Note the coincidence of my mother’s statement to me at the time our piano was repossessed when I was four years old: “We can’t make the monthly payments.”)

At my last place of employment my supervisor, employer, and coworkers said that I could become violent or even homicidal. In the current session I attempted to use that aggression, that defamation by coworkers, opportunistically to impose on my therapist
a duty to read my letters. I leverage other people’s aggression against me to serve my own ends, and psychologically to moderate the narcissistic injury resulting from others’ aggression. It’s as if I use opportunism to moderate narcissistic injury resulting from aggression (defamation). I see this trend in my personality as relating to narcissistic disturbance – a means of moderating narcissistic injury in the face of others’ aggression, which, in the above instances, centered on defamation. It’s as if I say to myself, “They say I am a bad person. That makes me feel bad. I will use other people’s perceptions that I am bad to serve my own needs. If I use other people’s criticism to serve my needs, I won’t feel bad – I will feel good.” Compare the typical narcissistic maneuver engaged in by Donald Trump and persons like him; Trump devalues people who criticize him, moderating the blow to his self-esteem by others’ criticism. In my case, I leverage other people’s aggression.

Is my tendency to leverage aggression directed at me related to my behavior in the oedipal situation? As a child, did I leverage my aunt’s narcissistic aggression to serve my own needs – my need to moderate my Oedipal anxiety in relation to my father? Did I use my aunt’s narcissistic aggression to neutralize my father’s power?

5. Neutralization of Aggressive Impulses through Drive Fusion and Sublimation

Psychoanalytic theory contemplates that the aggressive drive can be neutralized through fusion with the erotic drive – and that this admixture is then capable of sublimation.

To the extent that it is the sexual drives which best lend themselves to sublimation, the sublimation of aggression becomes possible primarily when aggression is joined with the libido. The psychoanalyst Alexander Mitscherlich observed that “adaptation must promote the admixture of drives, since as he observed through therapeutic practice, the decoupling of the drives makes it abundantly clear that aggression, as an object destroying force, untempered by the libido, possesses no capacity for sublimation.” Goebel, E. “Beyond Discontent: ‘Sublimation’ from Goethe to Lacan.”

The relationship of drive fusion to Oedipal development is clear from the following discussion:

The child’s dyadic relationship mother slowly merges into the oedipal triadic relationship with the parents by the end of the fourth year, ushering in a severely conflictual situation for children of both sexes. If identification with the parent of the same sex has been proceeding well, this identification now serves as a stabilizing force,
facilitating the temporary surrender of incestuous wishes and the modulation of hostile aggressive wishes towards the parent of the same sex. Sublimation of the sexual and aggressive drive derivatives can now proceed, with curiosity directed towards other areas. A significant landmark during latency is the gradual emergence of a scientific approach to learning and thinking. The why and wherefore of things become very important: concepts of the world and people begin to expand, and the development of reasoning steadily advances. Curiosity about sexuality gives way, under reasonably adequate psychological conditions, to curiosity about the wider aspects of the world, a sublimation of a portion of sexual as well as aggressive wishes that continues into adult life unless inhibitions arise because of psychological conflicts that were insufficiently resolved during the pre-oedipal and oedipal periods. Galenson, E. “Comments.” In: Ostow, M. Ultimate Intimacy: The Psychodynamics of Jewish Mysticism, pp. 144-150 at 150 (Madison, CT: International Universities Press, Inc.: 1995).

I have previously noted my therapist’s inability to deal with Oedipal issues; her almost exclusive concern for the mother-child relationship is often expressed in sessions with her reference to the “attachment dance.” As an individual with introjective as opposed to anaclitic pathology, Oedipal issues are predominant in me.

Circumstantial evidence for a high level of drive fusion (and consequent sublimation) in me can be seen in the results of my psychological testing (MMPI). My scale 6 (paranoia) and scale 4 (psychopathic deviate) were markedly elevated. A high 4-6 profile is an indicator of a very angry and possibly violent person. But my scale 5 (femininity) was also markedly elevated. The high scale 5 (corresponding to the libidinal drive?) possibly tempers or neutralizes the 4-6 code (corresponding to the aggressive drive?). I would propose that a markedly elevated 4-5-6 code combined with a high IQ is a marker of exceptional giftedness; in psychoanalytical terms it will signal the sublimation of fused libido.

I would propose that my letter writing is the outcome of a high level of drive fusion and consequent sublimation.

Does my possibly high level of drive fusion and consequent sublimation place me at risk of difficulties in group situations? Keep in mind that paranoid fight-flight basic assumptions groups are characterized by drive splitting and consequent projection onto outsiders or scapegoats within the group. In my last employment situation I was a scapegoat for the dominant group’s warded off, or projected, libidinal and aggressive drives. Thus, coworkers spread a rumor that I was a homosexual (a projection of forbidden libido) and also depicted me as violent and possibly homicidal (a projection
of forbidden aggression). Does my tendency toward drive fusion and sublimation set me apart from group-oriented persons who may regress under the pressures of group life to a state of drive splitting and projection of decoupled aggressive and libidinal impulses?

It is well to recall something I wrote in a previous letter about how my defenses may differ from the defenses of the dominant group and how that impairs my group relations:

“The group theorist Elliott Jaques observed that groups and institutions are used by their individual members to reinforce mechanisms of defense against anxiety and in particular against recurrence of the early paranoid and depressive anxieties first described by Melanie Klein. “On the Dynamics of Social Structure: A Contribution to the Psychoanalytical Study of Social Phenomena Deriving from the Views of Melanie Klein.” I am attracted to the idea that one of my difficulties in group situations centers in some way, perhaps, on my inability to share mechanisms of defense with the dominant defenses employed by most groups.”

APPENDIX TO LETTER (THERAPY SESSION: SEPTEMBER 11, 2017)

DREAM OF THE BOTANICAL MONOGRAPH – JUNE 11, 2017

Arnold Zweig (10 November 1887 – 26 November 1968) was a German writer and anti-war and antifascist activist. Zweig had written a book about antisemitism titled Caliban which he dedicated to Freud. Arnold Zweig was an associate of Freud’s.

Stefan Zweig was a writer who collaborated with the composer Richard Strauss on the opera, Die Schweigsame Frau (The Silent Woman). Perhaps Strauss’s most famous opera is Der Rosenkavalier which features a silver rose (a token of love) — the opera takes place in Vienna. Because Zweig was a Jew, the opera was banned by the Nazis.

In January 1991 I was in a car accident and suffered a fractured wrist and head concussion that caused a 2-hour coma (brain issue); I was hospitalized at GW. The doctor was John White, M.D. It was the beginning of the Gulf War in the Middle East. At work the firm (Akin Gump Strauss) sent me a plant or flowers — the sender was not identified. Later that year I was terminated by the firm under cloudy circumstances.

In January 1977 I worked at The Franklin Institute in Philadelphia. In about January 1977 I had given two white roses to a coworker named Sharon White at The Franklin
Institute where I was employed, together with a poem I had written. At that time I worked in an office with Silba Cunningham-Dunlop. Her Jewish father (Paul Frischauer), a writer, lived in Vienna (the city of his birth) at that time and had emigrated to Brazil during World War II to escape the Nazis. Silba’s father died four months later, in May 1977 of a brain tumor (astrocytoma — astoria?). The inauguration of Jimmy Carter took place on January 20, 1977. Carter was advised by Bob Strauss—the founder of the law firm where I worked years later, in January 1991.

In 1938 Freud wrote to Zweig from Vienna: “Everything is growing ever darker, more threatening, and the awareness of one’s own helplessness ever more importunate.” (I quoted this in my book, Significant Moments.) In 1977 Silba Cunningham-Dunlop and I worked on a monograph on the carcinogenic properties of ionizing and nonionizing radiation.

June 11 was the birthday of composer, Richard Strauss. That evening, June 11, 2017, I had the following dream:

I am in the living room of the house where I grew up. Although it is daytime, the room is dimly lit. (In fact the room was always dark; the living room had only one small window). Someone has left a floral arrangement on a table. They are deep red astorias. In fact there is no such flower. Someone has left a note attached to the flowers. It says, “Dark forces have overtaken Vienna, but the forces of light will someday return. Farewell, my beloved Vienna.” The note is signed Arnold Zweig. I sense that the note refers to the Nazi takeover of Austria in March 1938. I have the sense that sad events are happening elsewhere, but that I am safe in the living room of the house.

Every student of Freud’s will be familiar with the following dream.

Freud’s Dream of the Botanical Monograph is a short and sweet little ditty that goes a little something like this:

I had written a monograph on a certain plant. The book lay before me and I was at the moment turning over a folded coloured plate. Bound up in each copy there was a dried specimen of the plant, as though it had been taken from a herbarium.

Freud’s interpretation of this dream is complex, and he returns to it multiple times throughout The Interpretation of Dreams. The most important symbolic significance that he teases out of it relates to the meaning of the “certain plant” that he studies in the dream.
Because Freud “really had written something in the nature of a monograph on a plant,” the monograph in the dream reminds him of his work on the coca-plant. So, the “certain plant” in the dream becomes a symbol of Freud’s work on the medicinal properties of cocaine—as well as a symbol of his mixed feelings about that work.

Freud viewed his work on the coca-plant with both positive and negative associations: positive, because he prided himself on having made important contributions to anesthesiology; and negative, because his recommended use of cocaine as a painkiller led to the death of his friend and colleague Ernst Fleischl von Marxow. With this in mind, the symbolic significance of the “certain plant” in the dream doesn’t just relate to the coca-plant itself, but to a whole slew of Freud’s professional ambitions and anxieties as well.

The important fact for me about Freud and cocaine was that Freud had experimented on himself with the substance. The following associations come to mind:

ADDITIONAL ASSOCIATIONS:

In the spring of 1965, when I was 11, the following events transpired. I had the idea that I wanted to be a world famous scientist. I wanted to win a Nobel Prize in medicine. My first recollection of the Nobel was in the fall of 1964 (age 10), months earlier. Martin Luther King, Jr. had won the Peace Prize and my mother was incensed: “So now a convict gets a Nobel Prize!” My mother had strong racist convictions.

I had the idea that I would infect myself with poison ivy, a flowering plant, and then find a cure for the resulting rash. I stripped off the leaves of a poison ivy plant and rubbed them all over my face. (The German word Zweig means twig or branch in English.) I came down with a horrible rash and suffered terribly. When I went to school my sixth grade teacher (Olga Kaempfer), fearing that I had an infectious disease, sent me to see the school nurse (Rose Heckman). Mrs. Heckman said I had a poison ivy infection and told me to apply calamine lotion. Thus, my hopes of a brilliant future as a research scientist were dashed! I would be forced to find another road to world historical glory! That road would turn out to involve my relationship with Bob Strauss. (At age 3 I came down with scarlet fever. Our house had to be quarantined by the Philadelphia Department of Health (scarlet fever = deep red astorias?). This was a major emotional event from my childhood; the illness, which was blamed on my mother, caused a lot of tumult centering on my mother’s parenting and the embarrassment to my family caused by the Health Department quarantine. The Health Department
Department posted a notice on the front door of our house – a kind of scarlet letter. “You may not enter this premises.”

Freud’s dream of the botanical monograph related, in Freud’s analysis, to his earlier work on cocaine, derived from the coca plant. Like me, Freud had experimented on himself with cocaine. Like me, Freud had a lifelong desire to win a Nobel Prize; he was nominated for 12 years, but the nominations ceased forever when the Nobel committee engaged an expert who said that Freud’s work was of no proven scientific worth.

So my dream seems to relate to my narcissistic need for fame and my idea of experimenting on myself. These issues seem to be at play in my letter writing in which I record and analyze my therapeutic sessions – as if I were doing important scientific work. There is an aspect of dissociation here, or ego splitting, in which I am both the patient suffering from a disorder as well as the scientific researcher investigating that very disorder. In my therapy sessions it is as if I have taken on the complementary roles of the patient undergoing treatment as well as the psychoanalyst analyzing that patient.
PATIENT: So I have my letter about last week’s session. It took a lot out of me. It required a lot of deep thinking. It’s deep. Very deep. . . . So I’m still thinking about my letters. Why I write the letters. I have come up with so many different reasons for writing the letters. But this last week I thought of additional things. This last week I was thinking about the issue of child abuse. I read how devastating child abuse can be. You have the abuse victim generally alone in a room with an abuser. That’s like you and me alone in a room. And the victim has no witnesses. Nobody knows what is going on. It’s a secret. And I think about what that’s like: to experience something with no witnesses, with nobody knowing what’s going on. It must be devastating. And I wonder if at some level that reminds me of my situation here. It’s just you and me here. And I wonder if my letters are my way of preserving a record of what’s going on. That I experience this interaction as abusive, I have this fear of no one knowing what’s going on and I want someone someday to know just what goes on here.

I am reminded of something I read about a Nazi concentration camp inmate, maybe it was at Auschwitz. I read that this person thought about one thing in the camp that haunted her, it tormented her. She thought about it day and night. It wasn’t that she was going to die, or starve, but that all these things were going on and nobody in the outside world knew what was going on. It resonated with me when I read that. I was in college at the time. And for some reason that resonated with me, as if it related to my own feelings, my own experiences in some way. I wonder if those feelings relate to the
reason why I write these letters. All these things were going on when I was a kid and nobody knew anything about it. Maybe my letter writing is related to those feelings.

[Note how these ideas relate to the issue of confinement: confinement in a room and confinement in a concentration camp. Significantly, I had talked about my concerns about confinement at a previous session.

PATIENT: In the summer I can be outside. There’s a park bench in front of my building. I like to sit there in the summer. I just like to be out and about. But when the weather gets cold, I’m stuck in my apartment. I can’t go out. And I live in a tiny, one-room apartment. It’s so cramped, so confining. I’m stuck in there all winter. And also, there used to be a park outside my building. I would look out my window and I would see the park. Now, there’s just a wall across the way from me. All I see is a wall.

At the present session I never developed – or got to develop – the theme of confinement because I was led to focus on my childhood experiences in a dysfunctional family.]

THERAPIST: Tell me about your feelings when you were growing up. Do you want to continue with this?

PATIENT: Yes, well, I grew up in this disturbed, dysfunctional family. And, you know, there was so much brainwashing in my family that I didn’t know that we had an abnormal family. It didn’t register with me at the time that it was an abnormal family. I don’t know how I registered these things. In retrospect I think there were secrets in the family. I read that that’s a characteristic of dysfunctional families. That the family has secrets that nobody on the outside is supposed to know about. I remember when I was a teenager, I used to ask my father if I could see a psychiatrist and he would say, “No, you don’t need to see a psychiatrist. There’s nothing wrong with you.” Well, I don’t know why he didn’t want me to see a psychiatrist, but one of the possible reasons is he didn’t want an outsider to know what was going on in the family.

All of these people were abnormal and they validated each other’s pseudo-normality. Maybe I had a better chance to see what was going on in the family because I was an outsider. I don’t know. I don’t know how I registered these things.

The first inkling that there was something wrong in my family came in 1983. That was when I was already 29 years old.
[Compare the following: In a previous letter I talked about the Unabomber, Henry David Thoreau, and Martin Luther each training for a profession and then, at a relatively late age, becoming disillusioned and striking out on an independent path. In some sense the cult-like quality of my family parallels the cult-like quality of the Catholic Church. Erikson points out that Luther’s ultimate disillusionment with the Church was intimately connected to the fact that at an earlier age Luther had idealized the Church and believed that it offered the path to salvation. In his book Discourse on HAMLET and Hamlet, the psychoanalyst K.R. Eissler points out that the crusader is one who initially idealizes the institution that he later rails against. “What makes that description [of the crusader] so significant is that it suggests a man who . . . believes sincerely in the values of his time and his society and is ready as well as able to live up to them. This is someone who has formed his ideals and developed his superego in conformity with the standards of his cultural setting. . . . Yet the harmony of his personality has rested on the assumption that the society whose ideals he has integrated has its foundations in an ethical base. . . . [What we find in the case of crusaders is similar to] the situation of the truly religious person who has been leading a spotless life in conformity with the demands of the Sacred Texts. If it were now to be proved that these Sacred Texts are fraudulent or forged or otherwise invalid, such a faithful person would be thrown into a crisis . . . ]

Did my learning at age 29 of the psychological corruption of my family throw me into a crisis at a point after I had graduated law school? Had I, up until that moment in time, been a loyal and unquestioning adherent of my disturbed family’s value system?

(I quote Dr. Eissler’s book on Hamlet in my book Significant Moments in connection with my discussion of the anti-war activist Daniel Ellsberg, who was originally a pro-Viet Nam War hawk, that is, a true believer in the war’s aims. The theme of disillusionment is a strong and recurring theme in Significant Moments: Freud’s disillusionment with the seduction theory, Jeffrey Masson’s disillusionment with psychoanalysis (and his earlier disillusionment with the study of Sanskrit), Dr. Eissler’s disillusionment with Jeffrey Masson, Nietzsche’s disillusionment with Wagner, God’s disillusionment with mankind following the Garden of Eden debacle, and so on. God had wanted to create something perfect, but it didn’t work out as planned.

The following passage is at the core of Significant Moments:

At this particular point in Scripture, Creation seems to have come to a standstill. God speaks of Ketz kol bassar: He mentions the end, the mystical end. The term He uses is neither Sof nor Siyum (which also means the end), but Ketz: a brutal termination, a
breakdown of all systems—the closing of a spectacle that has barely opened . . . to poor notices, one might say. . . . It seems that Creation has broken away from its Creator. No wonder He was disappointed. It’s understandable. He had hoped to produce something unique: a work of purity and ecstasy, a colossal project with grandiose possibilities.

**Elie Wiesel, Sages and Dreamers.**

. . . a most majestic vision . . .

**William Shakespeare, The Tempest.**

And then came the letdown. He had been mistaken, misled, deceived. Deceived by His favorite and most privileged creature—betrayed by man, who appeared unworthy of His trust and kindness. Their relationship could have been so gratifying: it wasn’t. Why? Because man, in his foolishness, his pettiness, his selfishness, perverted and destroyed all. God therefore decided, Better put an end to it right then and there. Curtain, please. The author is dissatisfied with the performance. He chooses to work on another draft. And start all over. From the beginning.

*Elie Wiesel, Sages and Dreamers.*

The above passage highlights the mythical proportions of the theme of disillusionment in the book.

In the spring of 1983 my brother-in-law came down with ulcerative colitis.

[My brother-in-law had worked as an elementary school teacher from 1969, when he graduated college, to spring 1983. He gave up teaching in the spring of 1983 – at the precise moment he developed ulcerative colitis. He was now moving on into the business world. In 1990 Dr. Palombo asked me, “Why aren’t you practicing law?” He angrily answered his own question. “I’ll tell you what happened. You graduated from law school and you got scared!” Was my brother-in-law’s ulcerative colitis the physical effects of his “getting scared?”]

**THERAPIST:** What is that?

**PATIENT:** Ulcerative colitis. It’s inflammatory bowel disease.

When my sister told me about that I was curious about that. I had heard that there were psychological issues involved in ulcerative colitis. People who have it tend to transform their psychological distress into physical symptoms. It’s a form of somatization. Well, this was all very strange because my sister always said my brother-in-law was perfect. In early 1977 she said to me “Eddie is the perfect person. He’s the
perfectly developed person. Nothing bothers him. Other people worry about things.
Nothing ever worries him. He doesn’t even recall his dreams! Can you imagine how
emotionally developed he is that he doesn’t even recall his dreams? Everybody dreams
because they have things on their mind. But he doesn’t even dream because nothing
bothers him. He is the perfect person. He is the perfect son of the perfect mother. His
mother is such a good mother. If you had a mother like her you wouldn’t have the
problems you have. You have the problems you have because of who your mother is.
But Eddie has the perfect mother, so he’s a perfectly developed person.”

THERAPIST: What did your sister mean when she said your brother-in-law was perfect?

PATIENT: It was almost as if she were saying that he was ritually pure, without a taint of
sin. It’s like Christians believe when somebody is baptized. He is pure, he is free of sin.
There was almost a kind of mixture of the religious and the psychological, as if my sister
were saying he was psychologically pure and free of the taint of mental problems.

Anyway, I recently read that that’s a symptom of narcissistic disturbance: the belief
that one is the perfect child of the perfect mother. In any event, I was very curious
about this, about his ulcerative colitis. At that time I lived down the street from
Jefferson Medical College. So I went to Jefferson and I researched ulcerative colitis. And
I found articles that said that ulcerative colitis is associated with psychological
problems. And, you know, it dawned on me reading these articles that these were my
brother-in-law’s problems. These articles described my brother-in-law perfectly.

So that was in 1983. So that was the first time that cracks started to appear in the wall.
I first began to see that this image of my family was a false one. My sister always acted
as if I was the only one with problems in the family. But for the first time I could see
that that was not true. And that was an eye opener for me.

My family was like a cult. In the cult everybody is brainwashed and you believe that the
cult leader is perfect.

[Warren Brodey has observed that the dysfunctional family “uses its energy for what
the scientist would call ‘starting from the answer.’ Energy is not used for discovering a
more detailed and accurate image of self, other family members, or society. The
family’s hyperrealism has the neatness of a cultist’s certainty—‘the nonbelievers
purposely cause that which does not fit the expectation.’” “On the Dynamics of
Narcissism. I. Externalization and Early Ego Development.” The Psychoanalytic Study of
repetitious script—each validating the other’s projected wish. The family’s acknowledged reality is more rational and stable than life can be – until it breaks down. This is clinically familiar especially to those who have experienced the family with a schizophrenic member; it is also seen in other common ego disorders.”

THERAPIST: Who was the cult leader in your family?

PATIENT: I would say that was my aunt. She was like a cult leader. She didn’t have any real power, but everybody looked up to her as if she was an important person. It’s like the Queen of England. She has no real power. The power is in the prime minister and the government. But everybody looks up to the Queen as if she is the head of state, like she’s in control of everything. She’s not in control of anything. And that’s a form of power: to have people believe you’re the head of everything.

[I remember I told my father the anecdote in which my aunt had said to me, “I gave you everything you have. If it had been up to your father you would have had shit!” My father thought that was funny; it made him laugh. He said to me, “What did she ever give you? She didn’t give you anything.” She gave my parents a piano that had to be repossessed!]

[In a lengthy personality profile I wrote in 1999 and presented to my then-treating psychologist, Nancy Shaffer, Ph.D., I said:

To paraphrase, or apply, an observation that Thurman Arnold once made about the legal system: “parental authority in the family is primarily a great reservoir of emotionally important symbols, needs and gratifications: the rule of the parent within the family is based on the belief that there must be something behind and above the parent without which the parent cannot imbue himself with the qualities of authority or respect that might be conferred by the child on any other adult.” Lieberman, E.J. Acts of Will at 370 (New York: The Free Press, 1985) quoting Arnold, T. Symbols of Government (New Haven: Yale University Press, 1935). By implication, the arrogation of parental authority by a non-parent can be accomplished by a grandiose assumption of right (“entitlement”) combined with a system of rewards and punishments that lure other parties to acquiesce in the arrogation. This is precisely the dynamics found in certain cults, such as the Branch Davidians, in which the cult leader asserts a parental role over the children in the cult, an arrogation of parental rights acquiesced in by the biological parents, who themselves become de facto children vis-a-vis the cult leader. Cf. Brodey, W. M. “On the Dynamics of Narcissism” at 188 (comparing the dynamics of the narcissistically-disturbed family to that of a cult). Cf. FitzGerald, F. Fire in the Lake:
The Vietnamese and the Americans in Vietnam at 292-302 (Boston: Little, Brown and Company, 1972) (discussing the dynamics of colonialism, specifically the subversion of native authority by the colonial power).

Why is it that I have been talking about these issues for the past 20 or more years and none of my therapists process any of this? I remember trying to tell Dr. Palombo about problems in my family in 1990. He responded angrily: “What do you want me to do, condemn your family?” This is the influence of Freud: “It’s only the inner world that matters. Everything else is purely fantasy.” Dr. Palombo seemed to be exclusively concerned with the inner world. In his critique of Freudian analysis Jeffrey Masson once said with impressive cynicism and eloquence: “By shifting the emphasis from a real world of sadness, misery, and cruelty to an internal stage on which actors performed invented dramas for an invisible audience of their own creation, Freud began a trend away from the real world that, it seems to me, has come to a dead halt in the present-day sterility of psychoanalysis throughout the world.”

Focusing on the inner world alone is powerfully (and at times for the patient, devastatingly) distorting. I so admire the work of Dr. Shengold who views the inner world and the outer world like two intersecting circles in a Venn diagram. See n. 4, below. That is my style of thinking.

Additionally, the analyst must be careful that his inferences about the patient’s inner world comport fully with a detailed understanding of the patient’s outer world. In 1990 I told Dr. Palombo that my brother-in-law was anti-intellectual. Dr. Palombo interpreted my observation as a projection; that in fact it was I who was anti-intellectual. I have a telling anecdote. In the early 1980s I was at a shopping mall with my sister and brother-in-law. My sister and I drifted to a bookstore where my sister purchased a book. Knowing my brother-in-law’s proclivities I asked my sister, “What is Eddie going to do when he finds out you bought a book? (I knew he wouldn’t approve spending money on a book—books were a waste of money, in my brother-in-law’s mind). My sister’s response confirmed my “projection.” She said (knowing what I was thinking): “He’s never going to find out. I’m going to hide it under the bed.” Dr. Palombo seemed oblivious to the outer world.

Back to my aunt, the illusion of power is a form of power. The power of the magician lies in his illusion of power. The psychoanalyst Jeffrey Masson addresses this issue in his paper, “Buried Memories on the Acropolis: Freud’s Response to Mysticism and Anti-Semitism” International Journal of Psychoanalysis, 59: 199-208 (1978). Masson cites Thomas Mann’s short story Mario and the Magician as the model of a seductive and
manipulative individual – like the cult leader, mystic, or guru – whose hold over another individual or group is predicated on the illusion of power. Mario and the Magician is the story of a mystical demagogue’s attempt to keep his hold over a mountain community and win the villagers over to his brand of false nature mysticism. The intruder gradually seduces most of the community with his talk of a new mystical union between man and nature, his diatribes against modern technology [compare the Unabomber], and his preaching of the need for scapegoats and a sacrificial victim – who is duly killed as a ritual purification of the village. One aspect of the psychological acuity of Mann’s story is the intimate connection it shows between the holder of the illusion of power (the cult leader) and his victim or scapegoat. It is no mere coincidence that a cult-like family will assign one member the role of scapegoat or victim. The relationship between Mann’s magician and his victim vis-a-vis the community parallels my aunt’s relationship with me vis-a-vis the family as a whole.

(There is a multi-layered meaning to my reference to Masson’s paper “Buried Memories on the Acropolis.” In that paper Masson relates an anecdote from Freud’s childhood in which his Catholic nanny took the small Jewish boy to a Catholic church. My use of Catholic references in this letter appears to relate to my mother’s Catholic family and possibly to my sense of my therapist in some way.)

I think another source of my aunt’s power was her temper. She had outbursts. They were frightening. I think everybody in the family was afraid of her. I remember one time she lashed out at my father and he was dumb struck. Nobody wanted to antagonize her because you knew the way she might react. So you were careful to never antagonize her.

I thought my brother-in-law and my aunt were the most seriously disturbed people in my family. I think my brother-in-law had a narcissistic personality disorder. I think he fulfilled the criteria of a narcissistic personality disorder. I don’t know if my aunt had a narcissistic personality disorder, but she had strong narcissistic traits. She may have had borderline traits too: she had explosive anger like a borderline.

THERAPIST: So your aunt took away your sister and your brother-in-law took away your sister.

PATIENT: Well, with my brother-in-law, yeah. I mean he was very possessive. And that’s not just my imagination. Years ago, I was talking to my older niece – she was maybe 14 at the time – and she said that her parents only lived for each other. They had this exclusive relationship with each other. My niece said it was just the two of them. I
mean, my sister had two children, but my niece said it was like it was just her mother and father in this exclusive relationship. She said that to some degree she felt like an outsider in the relationship. It was just her mother and father. That’s the impression they gave. That it was just the two of them.

[Note that the therapist focuses on an anaclitic concern, namely, alienation. “Your brother-in-law took your sister away from you. She was no longer available to you.” This is a variation on the therapist’s idee fixe: “You wanted something from your mother, your didn’t get it, so you acted out to get attention.” Just as the therapist has in the past neglected the issue of mother’s objective empathic failures, so too in this instance the therapist ignores the fact that the relationship between my brother-in-law (and sister) and me was an emotionally abusive one that featured triangulation, projection, devaluation and exploitation. The therapist failed to address the issue of emotional abuse and its recognized consequences. Childhood emotional maltreatment contributes to impaired functioning in adulthood. If the experiences such as constant criticism, contempt, disapproval, rejection, put downs, and being ignored get internalized as global and negative beliefs about oneself, their negative impact will be enduring in adulthood. Clinical observations have revealed that individuals with traumatic events like emotional maltreatment in their childhood have more problems in relevant psychological tasks such as distress symptoms, interpersonal problems, and problems in experience of intimacy and forming mature relationships with authority figures in adulthood. The experience of emotional maltreatment can become a traumatic event that impairs the individual’s sense of integration. Farazmand, S. “Mediating Role of Maladaptive Schemas between Childhood Emotional Maltreatment and Psychological Distress among College Students.” Practice in Clinical Psychology, 3(3): 203-211 (2015). The therapist seems consistently unable to process the fact that the etiologic factor in introjective pathology is emotional abuse: a past in which important others have been controlling, overly-critical, punitive, judgmental, and intrusive—thus creating an environment in which independence and separation was made difficult.]

With my aunt taking my sister away, I don’t think so. My aunt didn’t take my sister away. It’s that my aunt took my mother away. My mother and aunt had this relationship where it was just the two of them. I could never complain about my aunt to my mother. She wouldn’t tolerate any complaints. If I reported something that my aunt said to me, if I complained, my mother would say in this rude manner, “If she says it, it must be right!” It was cult-like. It shows the fear that my mother had for my aunt that she couldn’t question anything she did or said.
There was strong evidence that my mother feared her older sister; she feared her explosive anger. My mother confided everything to her older sister. And yet, my mother never told her sister that my father on one occasion had tried to strangle her. My mother must have feared the explosive rage my aunt would have expressed if my mother ever divulged this secret. My mother told our neighbor about the incident (“Oh, will you still be going to Atlantic City this summer?” I remember the neighbor saying), but my mother never told her older sister.

There were just so many abnormal things going on in my family. I talked about the time when I was 12 years old and my aunt took me upstairs to clean the bathroom when I was home alone. My mother and aunt had this behavior that was very strange. When they were together – whether my aunt was at our house or my mother was at her house – my aunt would go into the bathroom with my mother while my aunt was on the toilet. My aunt would hold a conversation with my mother while she was on the toilet. And everybody knew this was going on but nobody thought there was anything strange about it. It was accepted behavior. Nobody questioned that.

THERAPIST: Maybe that was one of the reasons why you felt uncomfortable with your aunt taking you to the bathroom.

PATIENT: Probably it’s related. But I don’t think my aunt’s behavior was sexual. I told my previous therapist about this and he thought it was sexual. But it wasn’t sexual. It was infantilization. My aunt was treating my mother like a small child. It’s something a mother might do with a three-year-old child. It’s infantilization. Then there was a strange incident when I was 11 years old. It was in early 1965. My grandmother had come over to the house when nobody was home. My grandmother had a key to the house and she could come and go.

[Note the lack of boundaries in the family. An (abusive) grandmother who comes and goes with a front-door key. An aunt who intrudes on her younger sister while the younger sister is on the toilet.]

So she came over one day. It was a Friday. I remember that. And my grandmother got into an argument with the kid next door. He was only seven years old. At the height of the argument she said to the kid, “You can kiss my ass!” Well, who says that? Who gets into an argument with a seven year old kid and says, “You can kiss my ass?” The reason I know about that is that that evening the kid’s mother – our neighbor – came over and told my parents about the incident. She was very calm and rational about it. And she was not threatening in any way. But she told my parents, “I’m just saying that if
anything like this happens again, I’m calling the police.” The crazy thing is that my mother actually stood up for her mother. In my mother’s mind it was as if the kid had a problem. I felt sorry for our neighbor. I was only 11 but I could see this was a crazy situation.

[This anecdote shows that in my family if a protected object engaged in aggression against another, even a child, the protected object will be protected. It’s what we see with the Catholic Church that protects its priests against accusations of child abuse. The Church has no sympathy for the abused child, only the protected objects, the priests.]

I want to talk about something else.

THERAPIST: We only have about a minute left.

PATIENT: I had another idea about why I write letters. I think I have a recognition that you can’t do anything for me here. I am not going to accomplish anything here. It’s as if I want to preserve the material here for some future treatment, some future therapist who is able to make sense of all this material. I think about these people who are dying. They are terminal. They have an incurable disease. They get their bodies frozen. It’s cryogenics. At the moment they die, they’ve made arrangements that their bodies will be frozen and they will be thawed at some future time, some time in the future when there is a cure for what killed the person. I have that fantasy. It’s as if these letters were frozen samples of our work together. Perhaps some therapist at some future time would be able to read these letters and find them useful. The letters would help him treat me. They would help him cure me.

[Note the parallel of this fantasy to H.G. Wells’ Time Traveler in the novel The Time Machine who travels via a specially constructed machine to a distant epoch in the future. I had spent an entire past session talking about my thoughts concerning The Time Machine. It’s possibly significant that the story of The Time Machine perhaps had its origin in trauma: the fact that Wells’ had suffered a fractured leg (a traumatic injury) in childhood and that at the time of injury Wells’ time sense had been altered, a common event associated with a breach of the stimulus barrier. I am also reminded of something my father said on occasion. He reported that his father died in 1929 of an infectious disease, meningitis. My father would say, “Today they have antibiotics. When my father died they didn’t have antibiotics. If my father were alive today they could have saved his life with antibiotics.” My father was expressing what one might term a “cryogenic fantasy.”]
(I have a remote association to Freud’s Moses and Monotheism: “So I shall not publish this essay. But that need not hinder me from writing it. . . . Thus it may lie hid until the time comes when it may safely venture into the light of day, or until someone else who reaches the same opinions and conclusions can be told: ‘In darker days there lived a man who thought as you did.’”)

RANDOM THOUGHTS:

I suppose it’s useful for me to talk about my family background. Perhaps it’s useful for the therapist to hear an exposition of these matters to get a fuller understanding of my developmental environment. Perhaps, also, talking about these issues has abreactive or cathartic value for me, though I doubt it. At this stage I need analysis not catharsis.

I have concerns about presenting to a therapist a simple review of historical events, like a TV reporter presenting a story on the news.

When I talk about anecdotes from the past I don’t reveal anything new. I leave the session knowing exactly what I knew when I walked into the office. Nothing new is created when a patient talks about historical facts as a “procession of anecdotes.” There is a difference between a collection of anecdotes and an association of ideas. With an association of ideas the patient creates a context – a narrative based on unconsciously-determined associations whose component ideas express something from the unconscious. The narrative is something new. It never existed before. A procession of anecdotes is simply a verbal representation of historical facts about which the patient is already fully aware. Think of the difference between a diary or chronik that simply memorializes events and a memoir that “mixes memory and desire,” as T.S. Eliot would say.

I think of the following illustration of what I am saying. Let’s say I am unfamiliar with the Catholic religion. Someone takes me to a morning mass at a Catholic church. My companion says, “The adherents are sipping wine.” I am curious about this. I go home, log onto a computer and I Google “wine.” I get a collection of hits such as: “Wine exports and the French trade imbalance,” “Wine production in ancient Rome,” “Grape cultivation in California,” Wine shops in Washington, DC,” “Brian Bolter’s magnificent wine bar in Annapolis.”

Does this tell me anything about wine in the particular context that I witnessed that morning? The meaning of the wine in the church will only emerge upon looking at all the associated elements. What about the man in the funny costume presenting wafers
to parishioners? what about the wafers — what do they mean? why is there a huge statue of a cross with a man attached to it? why are people kneeling? All of these elements create a context. The meaning of the wine in this context is particularized and relates to all the other elements present. Of course, you could Google “wine wafers cross kneeling” and come up with useful information. And it is that Google search that is the work of analysis. Analysis is a collaborative search conducted by patient and analyst in a cooperative effort that looks at patterns in the patient’s thoughts and associations and feelings. It is a search for meaning that recognizes the overriding importance of context.

(In the first act of Wagner’s opera Parsifal, the character Parsifal, a naive youth, is taken to a great temple where a Communion service is held. Gurnemanz motions to the youth to participate, but he seems entranced and does not. Slowly the hall empties leaving only the young man and Gurnemanz, who asks him if he has understood what he has seen. When the lad cannot answer, Gurnemanz dismisses him as just a fool.)

When you extract one element and look at the meaning – for example if you Google “wine” – you will end up with meaningless information that does not clarify the meaning of wine in the context of Communion. Similarly, at this session it’s as if the therapist had said to me at the outset: Google the phrase “unpleasant events from Gary Freedman’s childhood.” What would the product of that Google search tell the therapist about the nature of my unconscious wishes, conflicts and prohibitions – my fantasies, my identifications, my opportunistic use of aversive experiences?

I started the session by saying I was concerned about my letter writing. I associated to the issue of child abuse and to a Nazi concentration camp. If I had associated to these ideas I would have created something new, a narrative susceptible to interpretation or analysis. Perhaps, my associations would shed light on why I would compare the therapeutic relationship to child abuse or a concentration camp experience. A patient’s mere recitation of aversive experiences from childhood will not explain why the adult patient would view the therapeutic relationship in the present moment as aversive.

The following statement I made at the outset of the session is so peculiar; it suggests some particularized meaning for me. How many of Dr. Shengold’s patients have ever said this to him? I doubt that a therapist’s directive to the patient to talk about aversive experiences in childhood will clarify the particularized meaning.

PATIENT: You have the abuse victim generally alone in a room with an abuser. That’s like you and me alone in a room.
(One cannot exclude the possibility that the statement actually expresses a primal scene fantasy in which perhaps the therapist and I represent my mother and father – and the abuse to which I refer is actually the sex act. The imagined third party who stands outside the situation is actually I as a young boy, the person “who does not know what is going on.” “You have the abuse victim generally alone in a room with an abuser. That’s like you and me alone in a room. And the victim [“the mother?”] has no witnesses. Nobody knows what is going on. It’s a secret. And I think about what that’s like: to experience something with no witnesses, with nobody knowing what’s going on. It must be devastating.” Perhaps the abuse victim and abuser are my mother and father alone in the bedroom. Did I perhaps as a child view the sex act as abuse; did I want to rescue my mother from her “abuser,” my father? Did I identify with my mother in the primal scene?

This is what I mean when I talk about the inner world and the outer world being two intersecting circles in a Venn diagram. The outer world was the actual abuse that I experienced in my family. The inner world is the primal scene. The intersection is the commingling of these two worlds. My desire to rescue my mother in the primal scene (inner world) intersects with my need for a rescuer from my abusive family (outer world).)

The therapist’s response, “Do you want to continue with this?” led me to enter into a procession of anecdotes that did not create anything new, simply a recitation of the old: verbal representations of past experiences.

Note how at the end of the session I returned to the idea that started the session: additional thoughts about my letter writing. Clearly, it was my letter writing that was on my mind. There was a quality of muted desperation about my attempt to slip in something that was pressing on me from my unconscious. It’s almost as if the entire session was a detour from what was on my mind when I entered the session. Speaking metaphorically, I ended the session still wanting to know what the wine had to do with the wafers and the man attached to the cross.

Instead, we ended up talking about Brian Bolter’s wine bar!

The psychoanalyst would be thinking: What does the concentration camp image have to do with his concerns about his grandfather’s meningitis? That’s an issue of psychoanalytic significance. There is some psychoanalytic wisdom in Dr. Palombo’s statement to me, “What do you want me to do, condemn you family?” I would add that you need to understand a patient’s outer world in depth to fully understand his
inner world. This reminds me of Bion’s belief that you could never fully understand a person’s inner world if you did not understand his functioning in groups. Things about a person will be disclosed in a group context that will never be revealed in a one-to-one interaction with an analyst. The cardiologist knows that a stress test will reveal things about a person’s heart functioning that will never be revealed in a resting state. Psychoanalysis must look at the total personality of the patient – the patient’s inner world as well as his reports about his functioning in the interpersonal field.

THERAPY SESSION: SEPTEMBER 25, 2017

Events prior to the session:

During my subway ride to the therapist’s office I was thinking about a young woman (SD) I had worked with forty years earlier, in the late 1970s. The following day, September 26th, was to be SD’s birthday. We were both born in the same year and graduated Penn State in 1975, though I did not know SD in college. Earlier in the day I had been researching SD on the Internet and learned that she had earned a 3.98 GPA at Penn State (Biology). When I learned that fact my immediate reaction was, “I knew she was brilliant.” I thought about how I had always been intimidated by SD’s intelligence. On the subway ride I thought, “I was smart enough to appreciate that. It’s because I was smart that I was intimidated by her brilliance because I could see how smart she was.” I thought about SD’s amazing ability to multitask. I thought in jest: “She could do calculus and a crossword puzzle all at the same time.”

My mind drifted to the physics Nobel laureate, Richard Feynman. I thought about the fact that Feynman’s wife had put in her divorce complaint, “he lies in bed all night doing calculus problems in his head for his own amusement.” I thought about the fact that average people thought Feynman was a just a friendly, witty guy who told funny anecdotes and played bongos. But his physics students were terrified of him because they knew how brilliant he was. Feynman had worked with the physicist J. Robert Oppenheimer on the Manhattan Project in the early 1940s that led to the development of the first atom bomb. Such were my thoughts on the subway ride on my way to my psychotherapy session on September 25th.
THE SESSION:

PATIENT: I have my letter about last week’s session.

THERAPIST: Do you want to talk about that or the two issues we left open last week

PATIENT: Let’s get into what you want to talk about first because my letter will require a long explanation.

THERAPIST: Last week we ran out of time and you wanted to say something. Do you want to talk about that now?

PATIENT: I forget what that was. Could you refresh my recollection?

[The therapist reviews the previous session. She is unable to remember the exact topic I had wanted to discuss but never got to discuss at the last session.]

PATIENT: Well, it doesn’t matter. If it was important I’ll remember it later.

THERAPIST: The other issue I wanted to get to was that when you were talking about seeing another therapist, your ideal therapist, you referred to that therapist as “he.” Do you want to talk about that? Your reference to a therapist as “he?”

PATIENT: Well, I said that for two reasons. The first is idiosyncratic and irrational. I would like to see a male therapist because I think I have a fear of engulfment by women. That issue would not arise with a male therapist. Based on things I read – I mean Kohut has talked about this and so has Peter Blos – early on I had a fear of engulfment by my mother. And I looked to my father as a defense against that. I idealized my father, I think, at least based on what I read. And because my father was distant I never got to work though my idealization of him. So now I idealize certain males. That’s the irrational meaning.

THERAPIST: I wouldn’t call that irrational. May people prefer either a male or female therapist.

PATIENT: Yeah. You know I was surprised recently when I was looking for a doctor on GW’s web page and they ask if the patient wants a male or a female doctor. I was surprised that GW would still cater to that.
THERAPIST: It’s perfectly acceptable for a person to want to see a male rather than a female. I can understand that a man might have a problem with a female doctor doing a digital rectal exam.

[At this moment I associated to the fact that in an earlier letter I had pointed out what I saw as “anal defensiveness” in the therapist. I was concerned with the therapist’s act of reducing my letters to objects that took up time to read, “mere words without any real sense or content”: her emphasis on a quantitative aspect of the letters (their length) rather than on the qualitative aspect of the letters, that is, their content or meaning. I viewed that as an example of “anal defensiveness.”]

PATIENT: Yes, I’ve heard that some women say they would never see a male gynecologist.

THERAPIST: It’s acceptable to have those feelings.

PATIENT: The other reason is cultural. I just automatically use the pronoun “he” when talking about random people. It’s a vestige of the past that I talk like that. . . . So let me get to what I wanted to talk about.

In the letter I talk about my concern for the inner world of intrapsychic functioning and the outer world of real experiences. Some therapists are only concerned with the inner world. The Freudian view is that it’s only the inner world that matters. Dr. Palombo was exclusively concerned with the inner world. I remember the time I was talking about my family and he said, “What do you want me to do, condemn your family?” But what about child abuse and the real life things that happen between people? I’ve talked about the primal scene in my letters: a child observing or imagining sexual intercourse between his parents. That’s a concern of psychoanalysts. Freud came up with that idea. According to theory the child imagines that it’s an act of violence by the father against the mother. Also, in Freudian theory you have the idea of the Oedipus complex: the boy’s fear of castration by the father in retaliation for the boy’s sexual desire for his mother. So in the internal world there are these ideas of violence: that sex is violence against the mother and that a boy can have a fear of castration by the father. So those things could have been going on with me in my inner world.

But what’s interesting about me is that these issues of violence also existed in the outer world. On one occasion my father actually tried to strangle my mother; he tried to murder her. So that was an actual act of violence by my father against my mother. And also my father used to beat me. So that was an act of violence against me by my
father. I’m wondering – can’t there be an actual meshing of the inner and outer worlds? That is, what about where a boy has these intrapsychic issues about violence against his mother and against himself by his father, but then in real life there actually is real violence against himself and his mother? Can’t there be a meshing of the inner and outer worlds?

So there’s this guy Albert Rothenberg up at Harvard. He’s a psychiatrist. He’s the guy that wrote that letter I showed you. The letter where he recommended Dr. Palombo to me. He’s an expert in creativity. One of his ideas is something called Janusian thinking. It’s named after the Roman god Janus. Janus is depicted as having two heads. One head looking one way and one head looking the other way. He’s the god of the portal, the doorway. You know how with a doorway, you go in or out? What Janusian thinking is where a person has these polar opposite ideas in his head. The person is able to hold these two polar opposite ideas in his mind at the same time and it gives rise to creations.

For example, Einstein’s theory of relativity is Janusian according to Dr. Rothenberg. Einstein had this idea in his head about a man jumping off a roof with an orange in his hand. So in mid-air he lets go of the orange. The man would be falling with respect to the earth, you know, because of gravity, but he’d be standing still with respect to the orange because the orange and the man would be falling at the same rate of speed. So the man would be falling and standing still at the same time. Those are polar opposite ideas. The idea of falling and standing still at the same time. And Einstein was able to work out the mathematics of that. And that became the theory of relativity.

[During this technical discussion the therapist appears to become increasingly restless and bored. She appears to have the idea that I am simply intellectualizing and not saying anything of clinical significance. And yet I become increasingly excited as I speak. My speech becomes pressured and rapid and I appear unusually animated or excited. Was my excitement in talking about these intellectual issues actually a screen for unconscious sexual feelings? Note the correspondence between my narrative about physics and Einstein working out mathematical problems, on the one hand, and, on the other, my thoughts about the young female coworker (SD) prior to the session. On the subway ride my mind had drifted to thoughts about physics and calculus. In the narrative I state, “And Einstein was able to work out the mathematics of that.” Note the therapist’s utter lack of curiosity about this oddity in my narrative, her lack of alertness about something significant that might be going on.]
In one of my previous letters to the therapist I had talked about how Einstein’s thoughts about relativity may have masked unconscious thoughts about aggression and sex. I had written:

Rothenberg observes that the key inspirational thought in the development of Einstein’s General Theory of Relativity concerned free-fall, and he attributes that thought to the negation of erotic and aggressive impulses. “Einstein’s focusing on a person falling from a roof could have represented an unconscious suicide wish (I am indebted to Sidney Blatt for this observation) or an unconscious wish to fly (= free sexuality). If so it would be an example of a revelation of unconscious material through the operation of the negation defense.” Rothenberg, A. “Janusian Thinking and Creativity.” In: The Psychoanalytic Study of Society. Volume 7: 1-30 at 24 n. 4. Gertrude R. Ticho, M.D., contributing editor (New Haven: Yale University Press, 1976). Rothenberg ignores the possibility that Einstein’s thought problem may have been inspired by an actual childhood trauma involving a fall, and he fails to consider the precise psychoanalytic implications of that possibility. What if Einstein’s thought problem had been inspired by the past registration, and later need to master, actual traumatic experience as opposed to internally-generated fantasy? See Therapy Summary, July 31, 2017. (Notice in this instance how Dr. Rothenberg’s reference to the erotic and aggressive drives (the inner world) triggered my immediate thoughts about trauma (the outer world)).

Also, I mentioned at the outset of this letter that the physicist Richard Feynman had worked on the Manhattan Project that developed the first atom bomb. Einstein’s work in physics had earlier shown that an atom bomb was theoretically possible. In my book The Emerald Archive I had conceived the idea of sex and a nuclear explosion simultaneously. See Appendix A.]

PATIENT: So Janusian thinking relates to issues in creativity. But what I wonder is if the concept has some applicability to pathology. What about a person who uses the inner world of intrapsychic fantasy to defend against the outer world of abuse, and uses the outer world of abuse to defend against the inner world of fantasy? What about that? I wonder if that’s possible. I think that might be going with me. I wonder what that would mean. Rothenberg bases his idea on the ego defense of negation. Negation is where you say something isn’t true, which masks the truth of the idea in the unconscious. For example, you’ve used negation here on two occasions. I noticed that. Or at least I think you used negation. On two occasions, you started by saying, “I am not scapegoating you when I say this.” And then you go on to say something that suggests you could be scapegoating me. Perhaps that was you using the ego defense of negation. Rothenberg says that what underlies Janusian thinking is something called
“simultaneous defensive negation.” Two polar opposite ideas that negate each other, allowing for the emergence of unconscious material.

Here’s the specific idea that intrigues me. In the primal scene that Freud talks about—and that relates to the person’s inner world of fantasy—you have the two parents alone in a room having sex and the child either observes that somehow or imagines it’s going on. The child is the third-party outsider to the sexual situation. Then in the case of child abuse—and that relates to the outer world of trauma and abuse—you have a child alone with an adult abuser who is abusing the child and the child imagines a third-party rescuer. So you have these parallel situations involving the inner world of fantasy and the outer world of abuse. And I wonder where in the case you have a child who is abused or grows up in an abusive environment, will he tend to defend against the inner world of fantasy with thoughts about the outer world of abuse and conversely, defend against the outer world of abuse through use of the inner world of fantasy. What I like to imagine in that instance is the inner world and the outer world being like two intersecting circles in a Venn diagram. The intersection would center on the three-person situations of the inner world of the primal scene, where the third-party outsider, the child, imagines the mother being abused by the father, and the outer world of real child abuse where the abused child imagines a third-party rescuer. I think that may be my situation because my father actually did beat me in real life, which corresponds to my inner fantasy concerns about castration, and he actually did try to strangle my mother, which corresponds to the child’s inner world of fantasy where the child imagines that in the sex act the father is committing an act of violence against the mother.

[At this moment I associate to Anna Freud and her work with children in London during World War II during the Blitzkrieg, the German bombing of London. I censor myself, fearing that the therapist will phase out. The therapist’s apparent boredom and restlessness has a censoring effect on me. I had wanted to mention to the therapist that Anna Freud found that she had a difficult time getting the children to immerse themselves in play therapy, they were unable to get into the world of intrapsychic fantasy. The children were so overwhelmed by the life-and-death circumstances of the bombing that they were preoccupied with their own survival. In that case the children’s outer world impinged on and prevented the expression of their inner world. And I wonder about the child who is the victim of an abusive environment. Will the experience of growing up in an abusive environment, such as mine, affect the development or expression of the drives in that child? That is a substantial question of interest. I was not able to explore these important ideas because of the censoring effect of the therapist’s lack of curiosity and boredom.]
PATIENT: This book I wrote with all the quotations. The book *Significant Moments*. It’s an expression of my concerns about the inner world and the outer world. I mix up quotes from literary texts and parallel historical texts. The literary texts correspond to the inner world of fantasy and the historical texts correspond to the outer world of real events. I wonder if the style or structure of the book relates back to this concern I have for the inner and outer worlds. I wonder if there’s something Janusian going on there. (A book review of *Significant Moments* states: “I am interested in how fictional literature matches real life situations. If you read the book you will see that I show parallels between literature and historical events,” said Freedman. ‘The book kind of blurs the distinction between reality and fantasy. I use literature to elucidate historical events.’” Summer 2013 edition of The Communicator, College of Communications, Penn State). I started working on that book in 1993. So this problem has been occupying me for 25 years! There’s a huge investment of mental energy in this subject.

THERAPIST: I notice that you became very excited as you were talking.

PATIENT: Yes! It’s what psychiatrists call “over-valued ideas.” I have over-valued ideas. I think my ideas are brilliant and awesome!

(I experience this as humorous. Note the absence of rage or shame in reaction to my therapist’s seeming lack of attunement with my thinking, her lack of admiration for my display of intellect. I am reminded of Kohut’s case of Mr. U., who had an engulfing mother and a distant father who did not permit Mr. U to work through, or moderate, his early father idealization. “Whereas a narcissistic personality disorder would demand attunement and admiration and become ashamed or enraged at not receiving it from his analyst, Mr. U attempted his sought-for merger with the idealized object through his attachment to the fetish.” Summers, F. Object Relations Theories and Psychopathology: A Comprehensive Text. I don’t need the admiration of others; I need to idealize objects (people, things, ideas). What does this mean? This seems to have diagnostic significance.

Is there no clinical significance to intellectualizations that preoccupy a patient for more than 20 years; that cause a clinical presentation that is sexualized; and that cause him to spend 11 years writing a book on that very issue? Is that simple intellectualization? Or something else? What does it mean where intellectualizations are charged with libido? Is there no clinical significance to that?

Let’s say a patient opens a psychotherapy session by stating: “I want to talk about Lincoln’s Gettysburg Address.” The therapist replies: “This isn’t a history seminar!” — But what about a situation where the patient has been obsessed with the Gettysburg Address for 25 years; spent 11 years writing a book about it; and becomes excited and
sexualized when he talks about it? Is there no clinical significance to that? Is the problem the patient’s intellectualization or the therapist’s lack of curiosity?

I suppose there are several ways to go about the question of the meaning of sexualized intellectualizations. Fairbairn associated sexualized intellectualizations with schizoid pathology. According to Fairbairn the schizoid experiences a “libidinal cathexis of internalized objects. The search for intellectual solutions of what are properly emotional problems thus gives rise to two important developments: (1) The thought processes become highly libidinized; and the world of thought tends to become the predominant sphere of creative activity and self-expression and (2) ideas tend to become substituted for feelings, and intellectual values for emotional values.”

Fairbairn, W.R.D. Psychoanalytic Studies of the Personality. In my case, however, the sexualized intellectualizations in this session may have been object-oriented; they may have been related to my thoughts about a young female coworker.

But then, on the other hand, K.R. Eissler observed that in the intellectually gifted individual, “mental activity is apparently so highly integrated and so intensely charged with energy that it becomes equivalent to physical genital discharge.” Note the odd and unintended allusion to the controlled nuclear fission reaction inside a nuclear reactor!

THERAPIST: You mentioned that your father tried to strangle your mother. You never talked about that before.

PATIENT: Yes, I want to talk about that. It’s actually quite complex. Actually I had mentioned that in a document I gave you at our first session. This happened when I was about ten years old. It was around Christmas time. I remember that. It was a Sunday morning. We were sitting at the kitchen table having breakfast. And my mother was going on about something with my father. I don’t remember what it was. But she was really nagging him about something. My father became enraged. He stood up, walked behind my mother and put his hands around her neck and started to strangle her.

[I am reminded of a passage from Dr. Shengold’s book about child abuse, *Soul Murder: The Effects of Childhood Abuse and Deprivation*: “The Sphinx is a monster with the head and breasts of a woman, the body of a lion, the wings of an eagle. The name literally means ‘strangler’ (compare the word sphincter); she would throttle and devour those who could not read her riddle. Sophocles calls her ‘the Dog-faced Witch.’ She has been held to represent the imago of the ‘terrible mother,’ the phallic mother, a depiction of
both parents in intercourse. Freud states simply that the Sphinx is ‘the monster who symbolizes the father.’”

The Sphinx represents a depiction of both parents in intercourse, that is, in the primal scene. Note the material that opened the session: my intellectualized references to the primal scene, highly charged material of analytic significance that seemed to bore the therapist. Did I register the scene in the kitchen, the scene where my father tried to strangle my mother, as a representation of the primal scene? What was the relationship, if any, between primal scene fantasy (inner world) and my registration of my father’s actual physical abuse of my mother (outer world), an issue relating to the real world of cruelty? Did the therapist not register this correspondence? And yet she was curious about my use of the pronoun “he” in my reference to therapists, a mere formality? (See discussion below.)

[I froze.] My sister started to scream. I think my sister screaming brought my father back to his senses and he stopped and walked away. My mother later said she was afraid she was going to die. She said she couldn’t breathe and she actually thought she was going to die. I actually felt sorry for my father. I didn’t sympathize with my mother. I could see what was going on: that my mother was trying to get on his nerves. I think I must have identified with my father. At some level I must have had the same sense of my mother. That she used to nag me. [It’s strange because my father used to beat me. So I was a victim of my father’s aggression, and yet I identified with my father in this situation.]

My father was always depressed around Christmas. Both his parents died around Christmas. His father died on New Year’s Day or New Year’s Eve in 1929 and his mother died on Christmas Day in 1933, four years later. My father was 23 years old when his father died. I was 22 when my father died. So my father lost his father at about the same age my own father died. My father said that he was very depressed after his father died. He said it took years for him to get over it. He once said, “Just as I was starting to get over my father’s death, my mother died, and I had to start the mourning process all over again.” That’s four years! So my father was grieving over his father for four years! There is some psychological meaning in that. It was like a lack of separation that he went on mourning that long. So my father was always depressed around Christmas every year. It was because of his parents. So that was the issue when he tried to strangle my mother.

Don’t you think the fact that I felt sorry for my father meant that I identified with my father in that situation?
So that was the only violence between my parents. Oh, wait, there was one other incident. It was when I was just an infant. My mother told me about this. And my father confirmed it. One time my father was painting the basement, the walls in the basement. And my mother was nagging him about the poor job he was doing. She just went on and on, and my father got enraged. He hurled the paint can at my mother and she got paint all over herself.

Anyway, there’s a back-story to that situation with my father trying to strangle my mother. As I said it’s complex.

In February 1963, I was 9 years old at the time, my aunt had a heart attack.

THERAPIST: You mean your mother’s sister.

PATIENT: Yes, my mother’s sister. She had a heart attack. And it was a major heart attack. I think they thought she was going to die.

[Note my earlier comment about my mother: “My mother later said she was afraid she was going to die. She said she couldn’t breathe and she actually thought she was going to die.” Are these ideas related to my thoughts about the London Blitz and Anna Freud? The children Anna Freud worked with during the London Blitz were afraid they were going to die and were unable to get into play therapy; they were unable to get into the world of intrapsychic fantasy. Because of the therapist’s unprofessional reaction to my narrative about Janusian thinking earlier in the narrative – my seeming intellectualization – I felt the need to censor myself and I never got to the core issue of the session: trauma, as encapsulated in thoughts about the London Blitz.]

She was bed ridden for months. This was back in 1963. At that time doctors recommended total bed rest for heart attack survivors. Today doctors recommend that patients get active as soon as possible. So my aunt needed a nurse to take care of her. She hatched this plan where she had this idea that my mother could work as my aunt’s nurse: go to her house every week and take care of her, clean her house, do her laundry and so on. My aunt would pay my mother. My mother needed the money and my aunt needed a nurse, so my aunt thought that would be a good idea. That reminds me of an episode of Seinfeld. Did you ever hear of the TV show Seinfeld?

THERAPIST: Yes.

PATIENT: There was this episode of *Seinfeld* where a judge sentences Jerry to be somebody’s butler.
[Notice my need to turn a serious matter into a joke. I wonder if this is a particularized
defense against trauma. I am reminded of the following quote of Wagner’s: “Oh, that is
my salvation, this ability to convert the most serious of things into nonsense in a
flash—it has always kept me from going over the brink.” *Cosima Wagner’s Diaries*
(August 6, 1878).]

Anyway, beginning in February 1963, my mother started to go up to my aunt’s house
twice a week. I remember, it was every Wednesday and every Friday. It was like a job
for my mother. My mother would send me off to school in the morning and right after
that she would drive up to my aunt’s house. It was about a 40 minute drive. My mother
would be there all day and come home late in the afternoon. My mother did my aunt’s
laundry, she cleaned her bathrooms. Notice that, how my aunt had my mother clean
her bathrooms. My aunt had me clean my bathroom. Remember that? My mother
cleaned the house, she did the laundry and ironing. My mother did everything but
cook. My aunt seemed to get better by the summer. She was no longer bed ridden. But
my mother continued going to my aunt’s house till the fall of 1965 when I started
junior high school. So from February 1963 till fall of 1965, my mother was going up to
my aunt’s house. I could see there was nothing wrong with my aunt. My aunt liked to
garden. That was her thing. I remember seeing my aunt carrying heavy rocks in her
garden, while my mother was cleaning her house. It was all kind of ridiculous that this
went on for two and a half years. There was nothing wrong with her. She was just
exploiting her illness. The same way I’m doing with Social Security. There’s nothing
wrong with me, but I collect all this money from Social Security. I’m exploiting my
“illness” the same way my aunt exploited hers.

In the summer time my mother used to bring me and my sister up to my aunt’s house.
Actually, it was kind of fun because there was a swimming pool near my aunt’s house.
And my mother would take my sister and me to the pool. We’d spend the entire day at
the pool while my mother was working at my aunt’s house. [I remember on one
occasion my aunt came to the pool with us. She was supposed to be recuperating from
a heart attack, remember!]

So this situation just disrupted the whole family. Because my mother was away all day
twice a week, my grandmother had to come over our house twice a week for me when
I came home from school. She made my lunch when I came home from school at noon,
and then she would be at the house in the afternoon when I got home. That’s what
happened in the incident with the neighbor where my grandmother said to the
neighbor’s kid, “You can kiss my ass.” My grandmother was there on a Friday when my
mother was at my aunt’s house. So twice a week I got stuck with my crazy grandmother – all because of my aunt’s heart attack.

Anyway, what happened was that my aunt and my mother started having these long conversations at my aunt’s house about how awful my father was. My aunt used to egg my mother on. She would tell my mother how to act around my father. “If he says this, then you do this.” “If he does this, then you just refuse to do such and such.” My aunt put ideas in my mother’s head. That’s what led to the strangling incident. My aunt had been putting ideas in my mother’s head about how to interact with my father. [Also, because my mother was now earning money on her own, she became more assertive. Because she was earning money on her own, she developed a sense of entitlement about how things should go in the marriage.]

Here’s the psychological thing. Years earlier, maybe when my aunt was in her twenties, she got a job as a housekeeper for a rich family in Philadelphia. The Chin family. They were rich Jews. She used to take care of the kids and clean the house. Maybe she had to clean the bathrooms. I don’t know. But my theory is that the whole thing with my mother was a kind of role reversal, as if my aunt was putting her younger sister, my mother, in the humiliating position that she had been in years earlier, having to be a maid. That’s my theory.

So you can see how dysfunctional the family was and how everybody’s dysfunctionality meshed with each other’s dysfunctionality. So you have my father who had a low-paying job; he couldn’t not support a family. He needed money. He wanted my mother to work to help out. My aunt has a heart attack. She has my mother work for her. She does this because she’s playing out some psychological drama from her past. So my aunt puts ideas in my mother’s head and that led to my father trying to strangle my mother. My father was depressed at the time because of separation issues surrounding his parents. And as a result I get stuck with my crazy grandmother twice a week for two and a half years who the neighbor threatens to call the police on. [As a result of my aunt’s heart attack, my father was almost arrested and my grandmother was almost arrested! All because of my aunt’s heart attack.]

My family was a crazy family. Don’t you think my family was a crazy family?

THERAPIST: I wouldn’t call your family crazy. It was dysfunctional.

[As a matter of fact, on one occasion, Dr. Palombo had dismissively referred to my family as “that crazy family of yours.” Note the fact that at the beginning of the hour}
the therapist asked me why I used the pronoun “he” to refer to a random therapist instead of “she.” Here the therapist corrects my use of a label; “crazy” instead of “dysfunctional.” (At an earlier session, the therapist mildly chastised me (“I feel you are judging your sister”) when I said that I felt I was emotionally stronger than my sister.) (I remember at the very first session I said to the therapist: “I have never seen a therapist so concerned with administrative issues as you are.”) Is the therapist over-concerned with labels and mere “formalities?” Does this reflect a superego disturbance in the therapist? Would such a superego disturbance be related to her anaclitic personality (her possible orality) and her possible lack of structuralization? Does the therapist have an over-concern for formulas and formalities?

I have a remote association to the Eichmann trial in Israel in 1962. The psychoanalyst Bela Grunberger writes: “When Eichmann listened to the enumeration of the monstrous crimes of which he was accused, he remained unmoved; for him they were obviously mere words without any real sense or content. [In the past the therapist has spoken of my letters as if they were mere words without any real sense or content that simply take up her time.] But when reminded by the judge that he should stand when addressed [a mere formality], he offered embarrassed apologies, stuttered, and reddened with shame. In this he felt himself guilty, since for a moment he had forgotten the rule of respect for superiors which had been taught him throughout his training.” Grunberger attributed Eichmann’s behavior to a pregenital (anal) superego; a superego which is based not on the introjection of complete objects but on part objects. I am not comparing the therapist to Eichmann. I am pointing out a feature of the pregenital superego. Speaking of female therapists, the noted female analyst Melanie Klein “observed a savage anal and oral superego in children” as young as two-and-three-quarter years old. That’s what “she” said! Baruch, E., et al. Women Analyze Women: In France, England, and the United States.

The therapist proceeds to offer several comments about my situation in my family and concludes with the following remark:] There was nobody to ally yourself with in your family.

PATIENT: Yes, it was like the war in Syria. It’s like the Syrian war. I once had a psychiatrist from Syria. I said the same thing to him. He agreed; he said it was like the Syrian War.
[I am reminded of one of Dr. Shengold’s abuse victim patients. Dr. Shengold wrote of him: “He spoke of life in military metaphor: as a war with battles, retreats, campaigns.” My reference to the Syrian war here seems related to the material at the beginning of the hour: my thoughts about the London Blitz during World War II. Because of the
therapist’s unprofessional reaction to my seeming intellectualizations I had self-censored these ideas.

Recall the comment above: “My mother later said she was afraid she was going to die. She said she couldn’t breathe and she actually thought she was going to die.” Are these ideas related to my thoughts about the London Blitz and Anna Freud? The children Anna Freud worked with during the London Blitz were afraid they were going to die and were unable to get into play therapy; they were unable to get into the world of intrapsychic fantasy. Because of the therapist’s unprofessional reaction to my narrative about Janusian thinking earlier in the narrative – my seeming intellectualization – I felt the need to censor myself and never got to a core issue of the session: trauma, as encapsulated in my censored thoughts about the London Blitz.

The therapist seems to betray the fact that she has no experience working with trauma or complex trauma. She doesn’t seem to pick up on the markers (sometimes subtle markers) of trauma in trauma survivors. Or am I only imagining that I was a victim of abuse?

APPENDIX A

From my novel, *The Emerald Archive*. Note the simultaneous conception of sex and a nuclear explosion:

**The Nuclear Fuck**

Like white heat the tightening yes releasing then immediately grabbing
again yes an explosion that rocks the entire body making
my back arch and Ben’s mouth open to gasp for
air as everything from the bottom of my box all
the way through the butterflies in my stomach ripples with
the force of pleasure yes the rhythmic waves pouring through
in bursts of energy like impacts yes I put my
arms around him yes and draw him down to me
so he can feel my perfumed breasts yes and his
heart is going like mad and yes I say Yes.

Paraphrases form the novel *Ulysses* by James Joyce and the short story “Overwhelmed” by Julian D’Angelos.

**PSYCHOTHERAPY SESSION – OCTOBER 2, 2017**

Introduction:

At this session the therapist appeared to be struggling with a high level of anxiety. Whether her anxiety related to her relationship with me (counter-transference) or to issues in her private life is not clear. The therapist’s behavior at the session seemed to reveal the following: the therapist’s high level of anxiety triggered a regression to splitting and projective defenses; the therapist exhibited a heightened need for nurturance (a need for the “good breast”) and a heightened hostility to my resistance and intellectualizations (the “bad penis”) which frustrated her need for nurturance (the “good breast”) (symbolized by this therapist by feelings and relationships). The therapist exhibited an almost desperate need at this session for me to talk about my feelings and relationships and a special need to ward off schizoid terror (the fear of the absent breast). The therapist’s regression disclosed a split in the therapist between “good self” and “bad self” imagos as seen in her dual, but split off, identifications with the “good vagina” (congruent with her good self) and the “bad penis” (congruent with her “bad self”).
Portions of my analysis in this letter are based on Kleinian object relations theory and specifically Klein’s theory about the “good breast” and the “bad penis.” Klein wrote: The first objects that [the girl] introjects are her “good” mother and her “bad” one, as represented by the breast. Her desire to suck or devour the penis is directly derived from her desire to do the same to her mother’s breast so that the frustration she suffers from the breast prepares the way for the feelings which her renewed frustration in regard to the penis arouses.

In Kleinian theory the good penis protects mother and infant (think of the police as viewed by the good citizen, who protects him from harm), while the bad penis frustrates the child’s access to the good breast (think of the police as viewed by the criminal, who frustrates the criminal in his desire for freedom). At this session there were indications that the therapist views my resistance and intellectualizations as the “bad penis” that frustrates her need to hear about my feelings and relationships (the good breast, i.e., the source of nurturance).

I believe there is a fundamental and direct relation between the therapist’s psychological response to me at the last session and my difficulties in some groups. In cohesive, homogeneous groups which place a premium on strong bonds and self-sameness, the individualist who places a premium on autonomy will be perceived as non-self and arouse anxiety in group members: that anxiety will trigger splitting and projective defenses in group members who will force warded off mental contents (namely, libidinal and aggressive impulses) into the non-self outsider by means of projective identification. A good analogy is the body’s immune response in which non-self tissue or foreign microorganisms will trigger attack by the immune system to preserve the integrity of self.

Significantly, Kernberg points out that in the cohesive, homogeneous group the group-as-whole is perceived by group members as the soothing “breast mother.” “The psychology of the group, then, reflects three sets of shared illusions: that the group is composed of individuals who are all equal [homogeneous], thus denying sexual differences and castration anxiety; (2) the group is self-engendered—that is, as a powerful mother of itself; and (3) that the group itself can repair all narcissistic lesions because it becomes an idealized “breast mother.”” Kernberg, O.F. Ideology, Conflict, and Leadership in Groups and Organizations.

May we say that the group’s anxiety in the face of the threat that the non-self individualist poses to the group-as-a-whole (the “breast mother”) directly parallels the therapist’s anxiety and heightened need for the “good breast” to ward off the schizoid
terror that my autonomy (my resistance) poses? May we define the therapist’s response (or counter-transference) to me as a paranoid-schizoid regression in the face of patient autonomy? Was the therapist in fact embroiled in a personal struggle aimed at warding off schizoid terror?

These questions lead to another question. Is it possible that my anxieties primarily center not on the paranoid-schizoid position but rather on the depressive position (guilt) and that this fact accounts for my difficulties in groups as well as issues surrounding my relationship with the therapist?

A study of Freud’s personality by the psychoanalyst Didier Anzieu offers tantalizing hints. Anzieu saw Freud’s theorization of psychoanalysis as a counterphobic defense against anxiety through intellectualization: permanently ruminating on the instinctive, emotional world that was the actual object of fear. From a Kleinian viewpoint, Anzieu considered Freud’s “elaboration of psychoanalytic theory . . . corresponded to a setting up of obsessional defenses against depressive anxiety”—emphasizing Freud’s need to “defend himself against it through such a degree of intellectualization.” Do I have powerful obsessional defenses against depressive anxiety that account for my obsessive intellectualized preoccupation with psychoanalysis? How would the dominance of depressive anxiety (and corresponding solitary defenses) in my personality affect my relationship with a therapist who falls back at times on paranoid-schizoid anxieties (with a corresponding need for social defenses)? How would the dominance of depressive anxiety in my personality affect my relationships in groups in which the shared social defenses against paranoid-schizoid anxieties by group members are a dominant glue that promote group cohesion? See Jaques, E. “On the Dynamics of Social Structure: A Contribution to the Psychoanalytical Study of Social Phenomena Deriving from the Views of Melanie Klein” (institutions are used by members in part to reinforce mechanisms of defense against early paranoid (and depressive anxieties) by unconsciously placing part of the contents of their deep inner lives outside themselves and pooling these parts in the emotional life of the group).

It is appealing to believe that unlike group-oriented individuals – including the therapist – who employ social defenses against dominant psychotic (paranoid-schizoid) anxieties, I use solitary defenses to ward off dominant psychotic (depressive) anxieties.

**ISSUES REGARDING COUNTERTRANSFERENCE:**

This session presents an oblique but striking continuation of the previous session (September 25) in which I talked about my desire to be in therapy with a male
therapist, which I attributed to an unconscious fear of engulfment by mother and a consequent need for idealized males as a defense against being swallowed up by a woman.

Let us turn for a moment to an issue of group theory.

One of Bion’s most interesting concepts described the presence of a dilemma that faces all of us in relation to any group or social system. He hypothesized that each of us has a predisposition to be either more afraid of what he called “engulfment” in a group or “extrusion” from a group. This intrinsic facet of each of us joins with the circumstances in any particular setting to move us to behave in ways that act upon this dilemma. For example, those of us who fear engulfment more intensely may vie for highly differentiated roles in the group such as leader or gatekeeper or scout or scapegoat. Those of us who fear extrusion more intensely may opt for less visible roles such as participant, voter, “ordinary citizen”, etc. Bion’s idea was that each of us may react upon one or the other side of this dilemma depending on the context, but that the question is always with us of how to “hold” the self, or, put another way, how to assure our personal survival within the life of the collective. Hayden, C. and Molenkamp, R.J. “Tavistock Primer II.”

My fear of engulfment in group situations militates against my homogenization in groups, the process whereby individuals dedifferentiate (lose their identity) and assume a group identity, that is, become a member of the group-as-a-whole. Unlike group-oriented individuals I need to retain my identity. I am one of those individuals Bion describes whose fear of engulfment by the group is greater than his fear of extrusion from the group. I am therefore at high risk of a differentiated role in groups, such as scapegoat. The terror I experience in groups is reactive: I fear and experience retaliation by paranoid (cohesive, homogeneous) group members who have an internalized terror about outsider status, that is individuals whose fear of extrusion from the group exceeds their fear of engulfment by the group. My internalized terror is the fear of loss of identity (which may be related to my fear of engulfment in relation to my mother).

Group oriented people don’t care about loss of identity (engulfment); they don’t fear being engulfed by the group. They are terrified of outsider status; they fear outsider status and will tend to terrorize the outsider in order to abreact their own terror about social rejection. Their terror is not reactive; it’s internalized.
Strong indications of counter-transference by the therapist in this session appear when one considers the fact that it was the therapist who raised the issue of why I wanted to see a male therapist (on September 25) combined with the fact that at the current session it was the therapist who honed in on the issue of my concern about group members spreading rumors that I was homosexual (i.e., their projecting libidinal impulses onto me) and focused on the issue of my feelings of paranoid-schizoid terror in reaction to workplace mobbing. Why did the therapist place these particular interrelated issues in controversy in two successive sessions?

The session on September 25, 2017 featured the following colloquy:

THERAPIST: The other issue I wanted to get to was that when you were talking about seeing another therapist, your ideal therapist, you referred to that therapist as “he.” Do you want to talk about that? Your reference to a therapist as “he?”

PATIENT: Well, I said that for two reasons. The first is idiosyncratic and irrational. I would like to see a male therapist because I think I have a fear of engulfment by women. That issue would not arise with a male therapist. Based on things I read – I mean Kohut has talked about this and so has Peter Blos – early on I had a fear of engulfment by my mother. And I looked to my father as a defense against that. I idealized my father, I think, at least based on what I read. And because my father was distant I never got to work though my idealization of him. So now I idealize certain males. That’s the irrational meaning.

My statements were based on Kohut’s thinking about his patient, Mr. U. “In early childhood, turning away from the ‘unreliable empathy’ of his mother – she would become overly involved with him, caressing him and meeting his wishes, and then suddenly withdraw and become unresponsive – Mr. U. had tried to gain ‘confirmation of his self’ through an idealizing relationship with his father. The ‘self-absorbed’ father, however, unable ‘to respond appropriately,’ ‘rebuffed his son’s attempt to be close to him, depriving him of the needed merger with the idealized self-object and, hence, of the opportunity for gradually recognizing the self-object’s shortcomings.’ Cowan, J.C. “D.H. Lawrence, Idealization, and Masculine Identity” and Summers, F. Object Relations Theories and Psychopathology: A Comprehensive Text.

The therapist’s concerns about my wanting to see a male therapist (arising from my fear of maternal engulfment) which arose on September 25 fit, like a lock and key, with issues that the therapist cherry-picked on October 2: namely, my difficulties in groups, which seem to be a consequence of my psychological autonomy, my fear of
engulfment by the group (the “breast mother”) – i.e., my inability to engage in homogenization or dedifferentiation, and my assimilation into the “group-as-a-whole.”

I had the sense at this session that the therapist was determined to get me to talk about my feelings and frustrate my desire to intellectualize and engage in resistance. It’s as if she were thinking, “Come hell or high water, I am going to get Gary to talk about his feelings today. I will not allow him to intellectualize.” I experienced the therapist’s approach as coercive – as if she were saying to me, “You need to take your medicine!” – and as almost an immersion in a depersonalized psychotherapeutic ritual of talking about feelings not because feelings are important to therapy per se, but because the immersion in the ritual of talking about feelings would moderate the therapist’s own anxiety. Menzies-Lyth, I. “Social Systems as a Defense Against Anxiety. An Empirical Study of the Nursing Service of a General Hospital” (the routinization of work by hospital nurses – such as forcing patients to take medicine at a particular time whether they needed it or not – was as a defense against the anxieties raised in nursing staff by caring for people in life and death situations).

The Session – October 2, 2017

PATIENT: I have my letter from last week. Something that has been troubling me is the problems with past therapists where they say I don’t talk about my feelings and don’t bring up important issues. I just intellectualize. It’s almost as if they’re saying, “Well how can I help you if you don’t tell me things.” So what I did was go back to my initial assessment at GW from, well it’s almost exactly 25 years ago. I had a two-hour assessment and it was a third year psychiatry resident, he did a two-hour assessment, and he wrote a chart. It was 4 pages long. I typed up the chart and added comments to the assessment — things that I thought the assessing psychiatrist missed or misinterpreted in his chart. The result is about 11 pages long, so I had a lot to say.

[I give a copy of the emended psychiatric chart to the therapist. She suggests we review the document together. She said, “How about if I make a copy of the document so we can both review the document together?” I decline, stating, “I know what’s in the document.” Then the therapist did a most remarkable thing. She scanned the opening of the document and focused on the statement in the chart that pointed out that my former coworkers at a law firm where I worked as a paralegal had spread a rumor that I was homosexual. Keep in mind that it was the therapist who cherry-picked that statement from the chart. What’s intriguing is that despite the fact that just moments earlier, the therapist had stated that she wanted to make a copy of the
document and review it in its entirety, she proceeded to ignore the document for the remainder of the session!

THERAPIST: Oh, here it says you had concerns people thought you were a homosexual. That issue keeps coming up. It reminds me of the dream you talked about where your psychiatrist chastised you because you called somebody a faggot. Was it faggot or queer?

PATIENT: It was queer.

[In July 1994, during out-patient psychotherapy with Dimitrios Georgopoulos, M.D., Dr. Georgopoulos became irritated when I related to him a dream in which I had said to myself, “Only a queer would smell another guy’s shirt.” Dr. Georgopoulos – ignoring the fact that the statement occurred in the nonvolitional context of a dream said angrily, “Homosexuals deserve to be respected. You shouldn’t use words like ‘queer’ to talk about homosexuals.” Notice how the therapist at this session switched the focus about interpersonal aggression in the workplace, namely, the spreading of sexual rumors about me, to a situation in which I had referred to homosexuals as ‘queers’ in a dream. In the therapist’s formulation I was no longer the target of group aggression, but, rather, an active agent who was defaming another. The text of the dream read:

I am looking at a man’s shirt; it is blue with a buttoned-down collar. I know intuitively that the shirt belongs to my friend Craig. There is no objective evidence that the shirt belongs to Craig, however. I look at a tag affixed to the shirt that indicates its size. I see that the collar measures 15.5″ and the sleeve measures 33″, which is my shirt size. I feel a great deal of satisfaction to learn that Craig and I wear the same size shirt. I have an impulse to smell the shirt. At that moment I think: “Only a queer would smell another guy’s shirt.” I examine the collar of the shirt and notice that it is frayed in one location.]

PATIENT: My coworkers also said I was homicidal, that they were afraid I might buy a gun, bring it to work and shoot everybody.

[I am describing my scapegoat status in a dysfunctional group in which I was the target of the group’s warded off libidinal impulses (“He’s a homosexual”) and aggressive impulses (“He’s a homicidal maniac”). Cf. Waska, R.T. “Hate, Projective Identification, and the Psychotherapist’s Struggle.” J Psychother Pract Res., 9(1): 33–38 (2000) [One manifestation of projective identification [such as that found in dysfunctional groups] is a forceful evacuation, in fantasy, of certain libidinal and aggressive states, leading to a penetration of both the internal and external object [i.e., the scapegoat]].]
THERAPIST: How was that for you?

PATIENT: It was terrifying. To be subject to all these accusations. All the paranoid accusations. It all seemed out of control. You didn’t know what you could be accused of. I had to deal all the time with people’s crazy ideas and behavior.

You know, it reminds me of an incident that happened at my aunt’s house when I was about 10 years old. My mother and I had been there all day and as we were leaving – well, I had some papers with me attached with a paper clip – my aunt noticed the paper clip I had as my mother and I were about to leave the house through the front doorway. Angrily, my aunt said to me, “That’s our paper clip! We have paper clips just like that one. That’s our paper clip! You stole our paper clip!” It was unbelievable that she had gotten so angry about a paper clip. And, by the way, I didn’t steal that paper clip. It was my paper clip. I refused to give it back.

[That seemingly trivial incident reminds me of something from Leonard Shengold’s book about child abuse, *Soul Murder: The Effects of Childhood Abuse and Deprivation*. Shengold reports a “fit of paranoid temper” evoked in a father by a boy by an utter triviality; the boy had rubbed off some bark on a tree in his father’s garden. Repetitive parental fits of paranoid temper in childhood can be pathogenic and represent for the child “the transformation of the good, empathic parent into the cannibalistically impatient, destructive, humorless parent (Sphinx)” Shengold at 214.

Oddly enough, this incident from my childhood involving the paranoid accusation that I had stolen a paper clip has a parallel from an incident that occurred in the workplace. On the day of my job termination, the hiring partner – keep in mind, the hiring partner at one of the largest law firms in the country – had me sift through a box containing my belongings, in his presence, including office supplies, such as, notepads, pens and paper clips, as if to ensure that I didn’t steal anything of value from the firm. These paranoid enactments with other people reverberate throughout my life. (That hiring partner later filed a perjured rationalization for my job termination with a state agency.]

PATIENT: So, I was in a paranoid group. The people I worked with constituted a paranoid group. I was unlike the people I worked with. [I was an alien force.] I told you that anecdote that happened a month after I started there. I was working with a paralegal in her office; she was about to get another job. She said she was never accepted by the other paralegals. She said she was older, had served in the army in the Netherlands. She said she thought the firm had a country club atmosphere – that people were hired more for their social skills than what they could offer professionally.
That set me apart because I had been hired because of specific skills I had. Then about two months later, the legal assistant administrator told me that the paralegals at the firm tended to be cliquish, that they might not accept me. She asked me if I was OK with that. I said, “Sure. I don’t care.” So I was always an outsider. It was a paranoid group that didn’t like outsiders, people who didn’t conform.

It reminds me of the Salem witch trials back in the 1600s. Did you ever hear about that?

THERAPIST: Yes.

PATIENT: I read a paper about that, a psychoanalytical explanation of what was going on. The community was a religiously orthodox group. They demanded strict observance of religious rituals. That was very important to them. You had to be an observing Christian. I read that some of the people accused of being witches were simply lax in their religious observance. For example, there was this one guy who couldn’t recite the Ten Commandments. Well, everybody in that community could recite the Ten Commandments. So they thought he must be a witch if he didn’t know the Ten Commandments. Then there was this other person who didn’t go to church regularly [coincidentally, the Jewish holiday of Yom Kippur was three days prior to this therapy session]. So that was a big thing. The fact that she didn’t go to church regularly [I did not attend services on Yom Kippur]. They said, “She must be a witch because she doesn’t go to church.”

THERAPIST: I also read that some of the people accused of being witches were seen as being hypersexual. So that fits in with your experience at work, that people spread rumors that you were a homosexual.

[It was the therapist who volunteered the observation that some of the accused witches at Salem were seen as hypersexual.]

[Some time later in the session, the therapist asked me about my feelings of “terror.” At first, I didn’t know what she was talking about. I said, “Did I talk about terror? Did I actually say I had feelings of terror? — Oh, yeah, I said I was ‘terrified.’” What the therapist had done was to retroactively cherry pick the idea of “terror” out of my report. Why did she do that? If “terror” was an important idea, why didn’t she ask about it at the moment I mentioned it? Why did she wait till some time later in the session? Is it possible that the emotion of terror had a special personal meaning for the therapist at this session? Was the therapist experiencing anxiety herself at the session]
that triggered a regression to paranoid-schizoid splitting and projective defenses? Was the therapist in fact projecting on to me her own feelings of schizoid terror in the face of my tendency to intellectualize and engage in resistance in therapy?

[Note the therapist’s inability to see connections between sessions: at this session she emphasized the issue of terror. Was there no connection with what I said at the previous session? I had reported that when my father tried to strangle my mother at the kitchen table when I was about 10 years old, my mother reported feelings of terror. I reported that my mother had said, “I thought I was going to die.” Each session seems to be a separate unit for the therapist who makes no attempt to see overarching concerns. To invoke a well-worn expression it’s as if she were in a forest describing each tree without any sense of the ecology of the forest, somewhat like the infant in the paranoid-schizoid phase who views the mother as a collection of part-objects rather than a unified whole: an image that only emerges with the depressive position.]

PATIENT: I had different strategies for coping with the stress at work. I used to walk 5 to 10 miles every evening after work. Or I would run every morning to decompress. I felt I was preparing for battle, as if I was a soldier facing combat and I needed to be ready for combat every day.

[The therapist talked about my ability to manage my anxiety and my ability to master the “terror” of the workplace.]

That I have a good ability to manage my anxiety should have come as no surprise to the therapist. Several months earlier I had spoken to her about my unusual self-soothing abilities. Why had the therapist blocked out the following report that I had related at an earlier session? Is the therapist blind to matters about me that don’t fit into her projective needs? Once again, the therapist shows she is unable to appreciate the ecology of the forest. I had earlier reported:

When my mother died in early January 1980 it was the first week of my second semester of the first year of law school. Despite the pressures of law school, I did not become vulnerable. I did my studies and finished my first year at the top 15% of my class.

When I got fired from my job in 1991, I didn’t become vulnerable at the termination meeting. Some fired employees might get into a tizzy with the employer, particularly one who was fired suddenly for no good reason and who had a stellar employment...
record. When I was told I was fired I just packed up my stuff and walked out. It was just another day at the office. The last day had come!

On the afternoon of October 12, 2004 I got a knock at the door. Outside my door were ten police officers and four FBI agents, some of whom entered my apartment. After talking to me for a while, they hauled me off in handcuffs to D.C. General for an emergency forensic psychiatric examination. I wasn’t particularly concerned. I thought, “I’ll talk to the psychiatrist and go home.” My only nagging concern was “How am I going to get home?” When the police hauled me off, they didn’t give me time to get my wallet. I had no wallet and no money. All I thought about at the hospital was, “How am I going to get home?” In the end the psychiatrist gave me money. Nice psychiatrist. (Diane Martin, M.D.).]

PATIENT: People ask why I stayed at the firm. Why I didn’t quit. It’s like therapy. I fight. I fight my therapists the way I fought the system at the firm.

THERAPIST: Why do you do that? Maybe you tried to fight or wanted to fight your aunt and your family. Maybe at the firm you were trying to fight the situation in your family.

I close down at these remarks. I feel the interpretation is forced and artificial: that the therapist is foisting ideas on me. I tell the therapist that interpretations need to flow naturally from things that the patient says. I feel that the interpretation does not flow naturally from anything I said. Do I experience the therapist’s interpretation as a rape, a forced intrusion?

THERAPIST: I am simply offering ideas that you are free to try on.

[Wilfred Bion’s observations about the role of group processes in group dynamics are set out in Experiences in Groups and other papers, written in the 1940s but compiled and published in 1961, where he refers to recurrent emotional states of groups as ‘basic assumptions’. Bion argues that in every group, two groups are actually present: the work group, and the basic assumption group. The work group is that aspect of group functioning which has to do with the primary task of the group—what the group has formed to accomplish; will “keep the group anchored to a sophisticated and rational level of behaviour.”

In the (paranoid) basic assumption of fight-flight, the group behaves as though it has met to preserve itself at all costs, and that this can only be done by running away from someone or fighting someone or something. In fight, the group may be characterized...
by aggressiveness and hostility; in flight, the group may chit-chat, tell stories, arrive late or any other activities that serve to avoid addressing the task at hand. The leader for this sort of group is one who can mobilize the group for attack, or lead it in flight.

Through the process of projective identification the group forces its unconscious contents — centering on aggressive and libidinal impulses — into the person (or entity or idea) who is fought. Hanna Segal observed that: “In projective identification parts of the self and internal objects are split off and projected into [or forced into] the external object, which then becomes possessed by, controlled and identified with the projected parts. Projective identification has manifold aims: it may be directed toward the ideal object to avoid separation, or it may be directed toward the bad object to gain control of the source of danger. Various parts of the self may be projected, with various aims: bad parts of the self may be projected in order to get rid of them as well as to attack and destroy the object, good parts may be projected to avoid separation or to keep them safe from bad things inside or to improve the external object through a kind of primitive projective reparation.”

Besides the elements that Segal clarifies, projective identification is an unconscious fantasy of loving (libidinal) and hateful (aggressive) feelings being evacuated or forced into the internal and external object.

To some extent the psychotherapy setting encapsulates the dynamics or processes of groups. The rational work task of therapy is the manifest work involving patient narrative and therapist interpretation. Underlying the rational work of therapy are the unconscious contents of therapist and patient which are designated transference and counter-transference.

I am able to identify the source of my feelings of distress about the therapist’s interpretation, namely, that perhaps I fought my employer the way I earlier fought or wanted to fight my aunt and my family.

Let me offer a somewhat fanciful metaphor or analogy. Let’s say a business owner is having labor/management problems. He hires a management consultant to offer advice on resolving the difficulties. Unknown to the business owner is the fact that the management consultant is a committed Communist. When the business owner talks about his rational concerns as a businessman and employer, the Communist business consultant interprets these concerns in the context of his ideology. Both the businessman and the consultant may talk about the same problems and even use the same language or jargon, but underlying the consultant’s advice about the rational
labor-management relations problems are ideas emanating from his ideology: when the businessman talks about labor-management problems, what the consultant hears are references to capitalist exploitation. The consultant’s advice emanates from ideology from deep within the consultant’s private irrational.

In fact, I did fight my employer and perhaps I did want to fight my aunt and my family, but the “fight” the therapist is talking about emanates not from my reality concerns but from deep within the therapist’s private irrational: her reference to “fight” is actually a reference to the therapist’s own counter-transference need to fight my seeming resistance and my intellectualizations (the “bad penis”), a struggle that was particularly prominent at this session. The therapist was projecting her private irrational concerns about “fight” onto me; she was attempting to force her private irrational into me like a “bad penis.” The dynamics of this session match the disturbed dynamics of the fight/flight basic assumptions group in which I was subjected to scapegoating at my former place of employment. The therapist’s “interpretation” is, in fact, projective identification (or counter-transference), or pure scapegoating, despite the fact that at some level there is a deceptive match between my reality concerns and the therapist’s private irrational concerns. But the therapist’s “fight” is not the same as my fight. By analogy “labor/management” problems are not the same thing as “capitalist exploitation” as it is meant by the Communist.

Let us now turn to the therapist’s statement: “I am simply offering ideas that you are free to try on.”

We know that the therapist volunteered several sexual comments at this session (“faggots or queers” “the Salem witches were seen as hypersexualized” “you seem concerned about your coworkers spreading rumors you were homosexual”). These sexual comments — unusual for this therapist — may signify that at this session the therapist was operating purely on counter-transference: that she was involved in a paranoid “fight” with my resistance, my intellectualizations and not with a rational therapy “work group” task of working with my resistance or my intellectualizations. The extrusion of the group’s warded off sexual contents is a major issue in the “fight” of fight/flight groups against the targeted enemy (scapegoat or other).

I am led to wonder, does the therapist’s statement “I am simply offering ideas that you are free to try on” in fact refer to the therapist’s vagina? Was the therapist saying, “I am offering you my vagina: see if it fits”? Was she saying, “a heterosexual patient would accept my interpretations (my vagina)? A homosexual patient would spurn my interpretations (my vagina)?”
Notice that the interpretation that the therapist offered ("Maybe you were fighting your family") was in fact projective identification. She was actually talking about her private irrational concern with "fighting" my resistance or my intellectualizations. She was also concerned with sexual issues at this session (a possible projection of her warded off sexual contents onto me as the scapegoat).

The interpretation ("Maybe you were fighting your family") was both a "bad penis" (a forced interpretation) and a vagina calculated to "fit" my concerns or behaviors. What I find possibly significant is that the therapist’s master’s thesis was on child sex molesters. Does the therapist identify with both the molester who forces his "bad penis" (in the therapy context, the therapist’s paranoid anxieties masquerading as interpretations) into another, a child, as well as the victim, the child, whose orifice offers a "fit" for the penis (in the therapy context, the therapist’s paranoid anxieties masquerading as interpretations)?

Does the therapist consciously conceive of her interpretations as a vagina that "fits" the patient’s concerns (congruent with her "good self"); but at the same time repress the fact that her interpretations are a "bad penis" that she forces into the resistant patient (congruent with her "bad self")?

PATIENT [embarking on a chain of associations]: I felt like a mountain climber [at work]. It was as if I was climbing high on a mountain and I was defying the heights. — No, wait! I was like a tightrope walker [in the workplace]. There were all these forces trying to bring me down but I was able to balance myself on the rope, I was able to do my job. I almost never took time off from work. There was a quality of triumph in that. It was a narcissistic triumph. Almost as if I was defying gravity. I was able to balance myself on the rope. There was a quality of excitement about that. There was a kind of sexualization of terror. Every day I could get fired, I could face the firing squad. But I continued on despite the constant threat of annihilation. There was this thrill and excitement associated with the terror. There is something sexualized about that. There must be some significance to the sexualization of terror.

I told you about that situation in 1998 when the U.S. Capitol Police came to my house. They thought I had threatened to shoot two Capitol Police officers at point blank range execution style in the Capitol rotunda. They banged on my door, yanked me out of my apartment, and frisked me in the doorway. They were screaming at me. My neighbors were staring at what was happening in the hallway. It was terrifying, but at the same time I got a thrill out of it. There was this peculiar manic excitement – a faintly pleasurable excitement – about this. I can’t explain it. Don’t you think this suggests
some kind of trauma in my background: the fact that I could get a thrill out of something so terrifying?

[Note that the word balance is a play on words. The tightrope walker balances himself on a high wire, while in the workplace I was able to preserve my mental balance in the face of forces that were trying to drive me crazy. See, Searles, H.F. “The Effort to Drive the Other Person Crazy: an Element in the Aetiology and Psychotherapy of Schizophrenia.” *Br J Med Psychol.*, 32(1):1-18 (1959). Also, we see my comparison of the workplace with the threat of immediate death. It appears that there is some parallel with the feelings I projected onto my mother in the previous session. “She thought she was going to die. She was convinced she was going to die” as a result of a physical assault (attempted strangulation) by my father. Note, significantly, how at the previous session I associated my father’s act of trying to strangle my mother with the sex act: I associated my father’s physical assault on my mother with sex in the primal scene. We see in my mind the commingling of terror, violence, and sex – with a consequent sense of triumph of the self, or narcissistic triumph. I seem to be expressing a sense of survivorship here: perhaps both the guilt and triumph of survivorship.]

PATIENT: I am reminded of the tightrope walker Philippe Petit. Back in 1976 he strung a cable between the two towers of the World Trade Center and walked across the cable. [I was enthralled by videos of that tightrope walking performance.]

[The tightrope walker traverses a wire strung between two posts. In essence the tightrope is a bridge that connects one post to another. Tightrope walking can involve a counterphobic attitude: the acrophobic individual, for example, may revel in what he most fears, the risk of falling from a height. Counterphobic attitude is a response to anxiety; instead of fleeing the source of fear in the manner of a phobia, the individual actively seeks it out, in the hope of overcoming the original anxiousness. The invocation of the metaphor of tightrope walking in therapy may have sexual significance since the bridge — or the tightrope walker’s wire as a connection between two points — has been seen to have sexual significance.

Leonard Shengold writes: “Anna Freud views adolescence as a ‘bridge between the diffuse infantile and the genitally centered adult sexuality.’ And there is something inherently incestuous about the bridge as a symbol, according to Ferenczi and Sigmund Freud, who felt that the bridge symbolizes the male genital, the father’s penis, which can be observed by the child as connecting the father to the mother in the primal scene. The bridge is often associated with water, a symbol of birth For the child of
either sex, acquiring the paternal phallus would provide the bridge that could bring the child back to the mother and her womb. Freud pointed out that the bridge can denote any kind of transition in life and that its use as a symbol has a special relation to birth and death.”

[Once again there are parallels between my reference to tightrope walking and my associations at the previous session: associations involving sudden death (through strangulation), the primal scene, sex, and the oedipal mother. The therapist ignored these sexual linkages relating to the oedipal mother focusing instead on the schizoid terror relating to the breast mother. Note that the introjective personality struggles with Oedipal issues and guilt (issues relating to the oedipal mother) while the anaclitic personality struggles with orality and dependency on attachments (issues relating to the breast mother).]

PATIENT: It’s funny I talk about tightrope walking and the fear of falling. Last week I talked about Einstein and his idea about a man jumping off a roof that led to the theory of relativity. Once again, it’s the theme of falling.

Also, last week I talked about the [traumatic] injury I had when I was two-and-a-half years old when I fell on a curtain rod and caused a serious injury in the mouth. That was another fall.

[Sidney Blatt suggests that Einstein’s thought experiment that featured a man falling off a roof may have indicated a sexual theme (free fall) mingled with an unconscious suicide wish.]

PATIENT: When I was at work I used to think of myself as a psychiatrist in a mental hospital. I was the one sane person in a group of crazy people. I was observing these people. I had a sense of superiority to these people. The job harassment fed into my grandiose sense of superiority and specialness.

[When I refer to myself as a psychiatrist in a mental hospital, I refer to a normal person in an alien environment. I am reminded of my preoccupation with H.G. Wells’ story of The Time Machine about a Time Traveler who transports himself from our own time to an distant epoch in the future where he experiences intense social alienation.

Also, there’s a transference issue here. I seem to be saying that in my relationship with the therapist I am the sane psychiatrist working with a patient (the therapist) who is mentally unbalanced. Thus we see the emergence of the theme of role reversal. I have
transformed in fantasy my therapist into the patient while I have assigned myself the role of the therapist. See Searles, H.F. “The Patient as Therapist to his Analyst.”]

PATIENT: I am reminded of that paper I read about how creative people get turned on by the idea of social rejection. Most people don’t like social rejection. They want to be accepted. They want to belong. Creative people, because of their independent self-concept actually get a thrill out of social rejection. The paper was called “Outsider Advantage: Social Rejection Fueling Creative Thought.” I am like that. Being rejected by people, at least in certain circumstances, pumps me up. I become more creative.

[The chain of associations point to the important sense I have of myself as someone who experiences narcissistic triumph in the face of social rejection. Kohut would see this as a transformation of archaic narcissism. The psychoanalyst Frank Lachman, referencing Kohut, points out that a measure of a person’s creativity is the ability to transcend the slings and arrows of outrageous critics (or workplace mobbers). To turn a humiliating rebuff into a triumph represents a developmental ideal in that it signals one of the transformations of archaic narcissism.

Kohut saw narcissistic triumph emerging out of a genuine decathexis of the self achieved slowly by an intact, well-functioning ego; and accompanied by sadness as the cathexis is transferred from the cherished self upon the supraindividual ideals and upon the world with which one identifies. Kohut saw narcissistic triumph as involving a “cosmic narcissism”: an admixture of quiet inner triumph (as in the triumph of survivorship?) and undenied melancholy (as in the guilt of survivorship?). Kohut, H. “Forms and Transformations of Narcissism.” Journal of the American Psychoanalytic Association, 14:243-272 (1966).

The creative individual triumphs over his detractors through a complex self-restorative solution in which a sometimes extreme, defiant, uncompromising stance allows the artist to defy social pressure – like the tightrope walker defying gravity – and withstand ridicule and isolation; in my creative transformation I displaced my personal conflicts — both intrapsychic and interpersonal — onto my book, Significant Moments which I began after my job termination.]

PATIENT: I learned a lot about groups while I was working. I was learning things every day—observing people, observing behaviors, observing groups. The aversive experience was intellectually stimulating.
[Learning from aversive experiences seems to be a routine aspect of my relationships with the environment. In the therapy situation, I transform my discomfort with the therapist through the self-restorative act of writing letters about my psychotherapy experience.

I am reminded of Bruno Bettelheim’s experiences in a Nazi concentration camp. During his imprisonment Bettelheim observed the behaviors of the prisoners and prison guards and later wrote a landmark paper on mass behavior in reaction to extreme circumstances. I am reminded of Erikson’s observations about Bettelheim: “He himself preserved his life and sanity by deliberately and persistently clinging to the historical Jewish identity of invincible spiritual and intellectual superiority over a physically superior outer world: he made his tormentors the subject of a silent research project which he safely delivered to the world of free letters.” In effect Bettelheim was able to endure his imprisonment through the intellectual defenses of observing and analyzing, and later engaging in the restorative act of writing about his experiences.

It is not simply that I fight my environment – my family or my coworkers or my therapist. There are superego issues here. I have a sense of myself as morally superior to those with whom I have aversive experiences. From my vantage point of presumed moral incorruptibility I view these others as corrupt. My fight is the fight of the whistleblower. Like the figure Emmanuel Goldstein in George Orwell’s novel, 1984, I expose the corruption of a rotten system – whether it be family, workplace group or inadequate therapists, while evoking and tolerating the enraged hatred of those whom I expose. Like Goldstein I don’t simply fight people, I fight what I perceive as their corruption. The figure Goldstein was a prototype of the whistleblower.

According to C. Fred Alford whistleblowers (moral narcissists) blow the whistle because they dread living with the corrupted self more than they dread living in isolation from others. Moral narcissists strive to live up to their “ego ideal,” as Freud would have it, rather than lower the ideal and say to themselves, consciously or not, “Well, I’m just going to go to work every day and go along.”]

PATIENT: But at the same time I have a fear of re-entering the workplace. I think all the problems could start all over again if I were to get another job. [My personality places me at high risk of workplace mobbing.]

THERAPIST: How do we resolve these feelings of terror?
In fact, my character pathology is complex. I do not have one single problem. I have many psychological issues that require a patient working through in a psychodynamic therapeutic context. It is key to understanding the therapist’s possible anxiety at this session to see that anxiety will trigger the unconscious paranoid-schizoid defense of splitting into dichotomous perceptions of the object as well as part-object splitting (“splitting into bits”) – in addition to the emergence in conscious thinking of simplistic solutions to complex problems. Hirschhorn, L. The Workplace Within: Psychodynamics of Organizational Life. Hirschhorn states that paranoid-schizoid thinking is simplistic, looking only at immediate relationships between part-objects. To think holistically (like the infant in the depressive position) requires the tolerance of anxiety. Anxiety causes individuals to revert to paranoid-schizoid thinking which defends the self by the dichotomous splitting of ideas into good and bad, thereby holding onto good thoughts and feelings and projecting out the bad. Unconscious splitting avoids the troubling nature of what learning may actually involve, so that a lack of appreciation of the complexity of the whole object vitiates the emergence of complex solutions and promotes the emergence of simplistic “quick fixes.” I propose that the therapist’s need at this session to find a “quick fix” for the social problems I experience as a result of my personality, as encapsulated in her statement “How do we resolve these feelings of terror?” was a reflection of the intensity of her own anxiety and the emergence of unconscious paranoid-schizoid anxiety.

And, incidentally, is there no relationship between the therapist’s tendency to lapse into simplistic thinking and my own difficulties in dysfunctional groups? Kernberg writes that under the regressed conditions of dysfunctional groups, “there is a projection of superego functions on the whole group [which parallels the conventional patient’s projection of superego functions onto the therapist], a projection that shows characteristics of a simplistic, conventional morality. . . . I propose that the temporary loss of the higher level of autonomous, abstract, and individualized superego functions as well, while a regression to the functioning of the latency child superego occurs, as well as the projection of his latency superego onto the group at large.” Kernberg adds: “Those individuals who resist [the] banal, cliché-ridden atmosphere [of the group at
large, like the autonomous patient who resists the simplistic thinking of the regressed therapist and try to maintain a semblance of individuality are the ones most attacked. It is as though the members of the large group envied people who kept their sanity [i.e., their mental balance] and individuality. . . . [A]t the same time, efforts at homogenization are prevalent, and any simplistic generalization or ideology that permeates the group can easily be adopted [by the regressed group member or, for that matter, the conventional therapy patient] and transformed into an experience of absolute truth.” Kernberg, O.F. Ideology, Conflict, and Leadership in Groups and Organizations at 265-266.

PATIENT: I don’t know how we resolve these feelings of terror.

THERAPIST: Have you ever had a relationship where you didn’t feel terrified?

PATIENT: Maybe not. Well, I had a girlfriend many years ago. I wasn’t terrified of her.

THERAPIST: Do you want to talk about that?

PATIENT: Not really.

THERAPIST: What happened there?

PATIENT: Well we talked about getting married, but I was in law school at the time, and I didn’t want to be married in law school. So it ended.

THERAPIST: It’s sounds like it was serious.

PATIENT: I guess you could say that.

[Here the therapist engages in a massive distortion of my character pathology. My feelings of terror in the workplace were reactive; they were a consequence of the workplace mobbing or group aggression. The actual cause of the workplace mobbing was my psychological autonomy in a cohesive, homogeneous group. My emotional reaction to mobbing was a normal reaction to a disturbed environment.

My social relations, my lack of social adjustment, is a disturbed reaction to normal circumstances mediated by my character pathology, namely, my lack of social interest (schizoid disorder), my dismissal of the value of relationships (dismissive avoidant
disorder), my high level of social discomfort, and my extravagant narcissistic need for idealization, twinship and mirroring.

The therapist’s line of analysis is bizarre. It would be like responding to a rape victim’s report of rape and consequent feelings of terror by asking, “Have you ever had a relationship with a man in which you didn’t experience terror?” The therapist is confusing a normal adverse response to a disturbed situation (rape, mobbing) with a disturbed response to an average expectable experience (normal social relations).

The therapist’s failure to distinguish a cause from a consequence merits comment. There is an intuitive bias to view consequences and causes as identical when in fact the cause of an event is often distinct from the consequence of an event. LeBoeuf, R.A. And Norton, M.I. “Consequence-Cause Matching: Looking to the Consequences of Events to Infer Their Causes.” One wonders if there is an issue of anxiety tolerance here. To overcome the reality distorting intuitive bias that prompts one to match causes and consequences, does one need to tolerate anxiety to look in depth at the cause of an event and look in depth at the consequence of the event? Was the therapist experiencing a high level of anxiety at this session that impaired her ability to distinguish a cause from a consequence?

PATIENT: I don’t see how my feelings in response to what was going on at work [i.e., the workplace mobbing] made any difference. They would have targeted me no matter what my emotional reaction was. Whether I was terrified or not terrified, it didn’t matter.

[The therapist is silent. There is nothing for her to say actually. The therapist had focused on the consequence of the problem (terror in response to workplace mobbing) and not the cause of the problem (the fact that I was scapegoated as an autonomous outsider in a cohesive, homogeneous group). I was left with feelings of confusion in this session. In fact, I propose that I had gotten caught up in the therapist’s need to work through her feelings of anxiety in reaction to my resistance (her schizoid terror) through her use of projective identification.

It is useful to translate the therapist’s statements:

You needed to fight your coworkers the way you needed to fight your family. Translation: I need to fight your resistance at this session.
You felt terror in the workplace. Translation: I experience schizoid terror in my relationship with you at this session because of your failure to respond to me affectively and develop an affective connection to me; your failure “to adopt my interpretations and transform them into an experience of absolute truth” like the conventional therapy patient, see Kernberg, arouses intense anxiety in me.

You need to talk about your past relationships at this session. Translation: Relationships are a source of nurturance, a derivative of the “good breast,” and the schizoid terror I experience at this session heightens my need to talk about feelings and relationships (derivatives of the good breast).

We need to resolve your feelings of terror. What can we do to resolve your feelings of terror? Translation: My anxiety at this session has triggered a regression to the paranoid-schizoid position and consequent failure to appreciate complexity and my need to find a “quick fix.”

THERAPIST: How does it feel talking about these feelings?

PATIENT: I suppose it’s good to tease out all these feelings.

[In fact, I experienced this session as disturbed, perhaps the worst session I ever had with this therapist. I felt coerced and exploited by the therapist’s own agenda. I felt like the child victim of an adult molester, using me for his own purposes. It seems clear that the psychological issues I raised at this session which grew out of my introjective pathology were not at all congruent with the therapist’s anaclitic agenda.]

**STRONG INDICATIONS OF COUNTER-TRANSFERENCE CAN BE SEEN IN THE THERAPIST’S ACT OF PATHOLOGIZING MY EXPECTABLE ADVERSE RESPONSE TO WORKPLACE MOBBING**

Group theorists observe that the fear or terrorization in groups is universal. All people have that fear. To moderate that fear, the group members will choose one group member (an individualist, a nonconformist, anyone who is not capable of homogenization) to be the carrier of the terror that all the group members fear. That group member will be terrorized — he becomes the repository of the warded off terror common to members of the group-as-a-whole. It is the universal fear of terrorization that promotes homogenization in groups.
“Among the most profound fears of group members, a fear that emerges early and
lessens only slowly is the fear of being ‘it,’ the scapegoat, the one sacrificed by the
group. A variant fear is that one member will psychologically terrorize another and
that no one will step into stop the mugging.” C. Fred Alford, Group Psychology and
Political Theory.

Mobbing is a form of emotional abuse in the workplace, such as “ganging up” by co-
workers, subordinates or superiors, to force someone out of the workplace through
rumor, innuendo, intimidation, humiliation, discrediting, and isolation.
Numerous reports in the literature refer to mobbing as a form of terror in the
workplace.

The classic paper is “Mobbing and psychological terror at workplaces.” Violence

A paper published by Viorel Constantinescu is titled “Mobbing: Psychological Terror in
the Workplace.”

Mobbing features the disturbed psychological processes of projection and projective
identification by the perpetrators onto the target and gaslighting by the perpetrators of
the target.

Projective identification is a disturbed psychological process that involves the
projection and reinternalization by the aggressor of an injured internal object causing
depression and schizoid terror in the perpetrator. That is to say, projective
identification in groups can involve the manipulation of terror by the perpetrator(s).

In projective identification parts of the self and internal objects are split off and
projected into the external object, which then becomes possessed by, controlled and
identified with the projected parts. Projective identification has manifold aims: it may
be directed toward the ideal object to avoid separation, or it may be directed toward
the bad object to gain control of the source of danger. Various parts of the self may be
projected, with various aims: bad parts of the self may be projected in order to get rid
of them as well as to attack and destroy the object, good parts may be projected to
avoid separation or to keep them safe from bad things inside or to improve the
external object through a kind of primitive projective reparation. Waska, R.T. “Hate,
Projective Identification, and the Psychotherapist’s Struggle.” J Psychother Pract
One manifestation of projective identification is a forceful evacuation, in fantasy, of certain libidinal (“he’s a homosexual”) and aggressive states (“he’s a homicidal maniac), leading to a penetration of both the internal and external object. This fantasy, in turn, can lead to either the fantasy of reinternalizing an injured object—causing depression and schizoid terror—or the fantasy of reinternalizing the now hostile and dangerous object—causing persecutory delusions. Projective identification also represents a means of communication in healthy whole-object relations. Although projective identification can foster ego maturity and integration, I will focus on the ways in which it can be a bullying way of relating. Id.

The severe consequences of workplace mobbing are documented. In mobbing targets with PTSD, Leymann notes that the “mental effects were fully comparable with PTSD from war or prison camp experiences.” Some patients may develop alcoholism or other substance abuse disorders. Family relationships routinely suffer. Workplace targets and witnesses may even develop brief psychotic episodes occupational psychosis generally with paranoid symptoms. Leymann estimated that 15% of suicides in Sweden could be directly attributed to workplace mobbing.

For the therapist to view my reaction to the disturbed process of workplace mobbing, which included feelings of terror, as an expression of my character pathology only is pure scapegoating and therefore counter-transference.

THERAPY SESSION – OCTOBER 16, 2017

I view the significance of this session to lie in the fact that it exposed the therapist’s inability to process a therapy narrative. I am able to prove that the ideas I talked about at the session proceeded along an unconsciously-driven path. The seemingly unrelated or discursive ideas I presented were actually an expression of a grand unconscious design.

As Freud pointed out, free associations in a psychoanalytic narrative are not random; rather, they are unconsciously determined – they follow an unconsciously-determined line of thinking that is in fact cohesive. It is apparent that the therapist does not appreciate this fact, that she sees my references in the session to be random and that apparent discursiveness (such as my sudden reference to Tolstoy’s Anna Karenina, for example) is a detour or an evasion from the work of therapy. It’s as if the therapist views my seeming discursiveness as an expression of resistance only. It’s as if the therapist interprets my apparent digressions in the following way: “Gary cannot face what he needs to face. He feels a need to switch the focus.”
An appreciation of the importance of free association is paramount in therapy. Is it that my digressions are simply my way of continuing my own agenda in the face of the therapist’s intrusions? That’s what Freud suggests in the following quote: “The importance of free association is that the patients spoke for themselves, rather than repeating the ideas of the analyst; they work through their own material, rather than parroting another’s suggestions”. My apparent digressions allow me to continue my agenda in the face of the therapist’s intrusion – by taking a modified route, like a composer repeating a melody in another key with a radically different harmonization.

At the outset of the session the therapist didn’t seem particularly interested in my discussion of Weisman’s theories about creativity and the infant’s relationship with mother. Later she appeared to become dejected when I talked in the session about Anna Karenina. Lo, and behold, these were the very same associations that arose in a letter I wrote to a previous treating psychiatrist in 1993 – twenty-four years ago. See Appendix A. The therapist seemed to take a keen interest at one point in something I said about my mother: that I regretted that my mother didn’t take me to the library when I was a child. The therapist focused on that observation as if it were of singular importance and (projectively) imposed a meaning on that anecdote that deviated radically from the import of my many other associations.

In an important sense we can see this session as revolving around the presentation of a theme followed by an elaboration of that theme, or a collection of variations on that theme. The essential theme of the session was loss and the evocation of loss in fantasy.

The therapist was clearly unable to follow my therapy narrative – that is, the import of the totality of my narrative – and seemed intent on imposing her own (projective) agenda on selected associations, references, or anecdotes that I relate.

May we frame the conflict between the therapist and me as one between an orally-fixated therapist intent on projecting her symbolic need to locate and suck the breast (“You felt bad in your mother’s absence and long for closeness with her”) onto my psychological preoccupation that seems to center on the lost breast and my hypercathectic of an idealized substitute (a manic defense against loss of the whole object) (“I feel conflicted by the disparity between my real mother and my fantasied ideal mother and long for a lived relationship with my fantasied ideal mother” and “my act of spurning my real mother has induced feelings of guilt in me and the desire to make reparations?”)

THE SESSION:
PATIENT: I have my letter about last week’s session. I was thinking that perhaps my personality problems exceed your competence. Have you ever thought about that? The possibility that my personality problems exceed your competence? I was thinking that it would be good if you showed this last letter I wrote to a psychoanalyst. Maybe he could tell if my personality problems indicate that I need to see someone else[, maybe a psychodynamic therapist]. Do you know any psychoanalysts?

THERAPIST [appearing to reflect]: I don’t think I know any psychoanalysts. Psychoanalysis fell out of favor with therapists years ago. Now, psychoanalysis is experiencing a resurgence. Therapists developed a concern for evidence-based treatments. That’s why CBT [cognitive-behavioral therapy] became popular.

[I view the therapist’s response as evasive. She doesn’t know whether or not she knows any psychoanalysts? And why the discourse on therapy orientations?]

PATIENT: Anyway I think I would like to be in psychoanalysis. I think I could benefit from psychoanalysis. But that’s just not feasible for me.

THERAPIST: Have you looked into psychoanalysis as an option?

PATIENT: Well, I guess I could get involved in psychoanalysis at a training center. They would have a sliding scale, but even that would be too expensive for me.

THERAPIST: Because of the frequency of psychoanalytic sessions, you might be charged as low as $90 per session.

PATIENT: Well, that would be too expensive for me. You know, I was doing research and I found that there are a lot of psychoanalyst social workers – social workers who are trained psychoanalysts. I came across this one woman in New York who is a psychoanalytic social worker (Ashley Warner). She has an interest in creativity too. So she would be a good person for me. But she’s in New York – so I couldn’t see her for geographic and financial reasons.

Anyway, I’m thinking about how my whole emotional investment is in my letters, not in my therapy with you or my relationship with you. I view my relationship with you as merely an inspiration [or springboard] for my letters. I am not concerned about my lived relationship with you. My emotional investment is in my imaginative perception
of my relationship with you. My emotional investment is in how I transform our relationship in my letters.

It reminds me of something I read about potentially-creative infants. Someone wrote that the potentially creative infant had the ability to hallucinate the mother’s breast independent of the mother. I don’t know how analysts know what goes on in the mind of infants, but, anyhow, they say that, so, a baby is fed by the mother – and that’s like my lived relationship with you – but the potentially creative infant will be put down in the crib by his mother and the baby will start hallucinating his breast feeding experiences with his mother. Non-creative infants won’t do that. They can become enraged by being put down in the crib, losing that valuable connection with their mother, the feeding experience with the mother. Anyhow, that’s how I view my letters to you. So I see you every week – that’s like the feeding – then I go home and start thinking and analyzing our sessions, and I write my letters like the baby alone in his crib hallucinating the mother’s breast.

THERAPIST: What is the outcome of that baby hallucinating the mother in that way?

PATIENT: Well, creative products in adulthood: like an artist painting pictures or a writer writing novels.

[I sense that my observations are disconcerting for the therapist, that somehow these ideas don’t fit in with her view that the child has an ever-present need for the mother’s actual presence and that the therapist is troubled that there are certain infants (potentially-creative infants) who have the ability to use their imagination as a substitute for needs gratifications.

The therapist failed to see the connection between my description of the creative infant hallucinating the mother’s breast with my dissatisfaction with her as a therapist (mother representative) and my creation in fantasy of the ideal therapist or psychoanalyst with whom I imagine a therapeutic relationship. That is, the creative infant hallucinating the mother’s breast (or ideal breast) in mother’s absence corresponds to my hallucinating the ideal psychoanalyst. She fails to see the connection of my report about the creative infant to my letter writing activity – what one might term a hallucinated communication with the ideal psychoanalyst.

My ideas about the infant hallucinating the mother’s breast in her absence come from a book about creativity I read in 1985 titled Creativity: The Magic Synthesis by the psychiatrist/psychoanalyst, Silvano Arieti, M.D. who wrote:
“[Philip Weismann] believed that the future artist, as an infant, had the ability to hallucinate the mother’s breast independently of oral needs. According to him the unusual capacities of the artist ‘may be traced to the infancy and childhood of the artist wherein we find that he is drawn by the nature of his artistic endowment to preserve (or immortalize) his hallucinated response to the mother’s breast independent of his needs gratifications’ . . . . One major concept of Weismann is the ‘dissociative function of the ego’ that he substitutes for Kris’s concept of regression in the service of the ego. With the aid of this dissociative function, the creative person ‘may partially decathect the external object (mother’s breast) and hypercathect his imaginative perception of it. He may then further elaborate and synthesize these self-created perceptions as anlagen or precursors of creative activity which must then await full maturation and development of his ego and his talent for true creative expression.’ In simple words, according to Weismann, the child who will become creative has the ability to diverge the energy originally invested in primitive personal objects and to invest it again in creative work.”


PATIENT: Anyhow, my preoccupation is not with my relationship with you, but with the letters I write. My whole emotional investment is in the letters. I suspect most therapy patients don’t think like that. For most therapy patients, it is the actual relationship with the therapist that’s important, not the patient’s retrospective recollections of the therapy session.

I am reminded of something that the writer Andre Aciman wrote. He’s a novelist. He talked about how he will be writing all day. Then in the evening he will go out to party. And, sure, he loves his friends and enjoys the party, but, at the same time, as the evening wears on, he wants to get back to his writing desk. It’s the writing that is ultimately important to him. He talked about how, while at the party, he thinks that maybe he will incorporate actual conversations he had or overheard at the party into the novel he is working on. It reminds me so much of my letter writing. As I am sitting here, I think about writing my letters.

Something I wonder about is whether I had the ability to dissociate in infancy, which allowed me to survive my childhood, or whether my ability to hallucinate is an ego defense that I developed later in childhood in response to the trauma or adverse circumstances of my disturbed family. This goes to the dual nature of dissociation. It has both adaptive qualities that can be associated with creativity but it’s also an ego defense that can emerge in response to trauma.
Harold Blum has written that dissociation may be defensive, adaptive, or protective, and may serve multiple functions. Clinically, dissociation generally involves denial, isolation, and various forms of splitting of the self and the ego. Altered states of consciousness are characteristic of dissociation. Dissociative disorder may be transient or enduring, entailing division of the personality without full conscious awareness of the divided self. Dissociative disorders are typically a consequence of severe, protracted trauma, or a serious disturbance of the infantile primary object relationship. These disorders are closely associated with borderline personality, propensity for regression, and significant disturbance of identity and reality. While dissociative disorders are maladaptive, dissociation may paradoxically facilitate novel self-object configurations, imagination, and creativity. Blum, H. “Dissociation and Its Disorders.” *Psychoanalytic Inquiry*, 33(5): 2013.

A study that looked at the relation between creativity, dissociation and sleep, seemed to demonstrate that regular exposure to abuse that precipitates dissociative states can set up a fertile ground for the development of imagination, fantasy and even creativity. Van Heugten van der Kloet, D. “Imagining the Impossible Before Breakfast: the Relations between Creativity, Dissociation, and Sleep.” *Front. Psychol.*, 26 March 2015.

This is just rank speculation, but is it possible that the special loss sensitivity in the potentially creative infant causes him to experience routine absences from mother as traumatic which, in turn, triggers the emergence of a dissociative defense? Is “loss sensitivity” in the potentially creative infant a key variable in the development of his creativity?

Gilbert Rose, who writes about creativity, notes that loss is often at the root of the creative process, perhaps less because of the nature of the loss than because of the similarity of the artist to the sensitive child. He wonders why, since loss is “inevitable” in life, so many artists are preoccupied by it. He answers the question by reflecting on the kind of disposition an artist might start out with: “A creatively endowed child could well experience early loss more intensely than an average child. . . . The more intense sensuous engagement with the world might make for both deeper and wider rootedness of attachments.” In a sense, the ups and downs of early development might be difficult, since “For a creatively gifted child, the very process of individuation might be experienced as a loss—a narcissistic loss to the child’s idealized sense . . . of omnipotence, for by definition the creative artist might start out “loss-sensitive and separation prone.” Scheftel, S. “The Children’s Books of William Steig: a Creative Representation of Early Separation and Resiliency,” *Psychoanalytic Study of the Child*
2009. One wonders whether, importantly, Rose’s ideas about the creative infant’s response to loss encompasses the daily routine loss attendant to child care and feeding. On a daily basis the mother feeds the infant, then “abandons” the child to his crib. Does the creative infant experience that routine separation as a kind of traumatic abandonment that triggers the emergence of a dissociative defense?

In some sense, all creativity is the evocation of a lost object. Betty, N.S. “Creativity: The Adaptive Aspects of Insecure Attachment.” The psychoanalyst Albert Mason has said that true creativity can only occur with depression; that is a loss, and is simultaneously an attempt to repair or recreate what has been lost. Id. “This difference, restoring the object rather than the self, reflects the crucial differences between the artist’s and the psychotic’s relation to his creation and the means which each employs” (Segal). Id. “In order to think creatively, absent objects and events have to be evoked in the mind by symbolic means; in particular by play, drawing, and language” (Miller). Id. “Creativity is a form of object relatedness” (Oremland). Id.

PATIENT: So dissociation can be both adaptive and a defensive result of trauma.

THERAPIST: Dissociation has adaptive value. It allows us to put difficult circumstances out of our minds and carry on with our activities.

PATIENT: It reminds me of my desire for psychoanalysis. Is it a healthy desire on my part or actually an aspect of my pathology. I mean, I wonder about that. Do I want psychoanalysis because I have a rational idea that that’s a treatment that could help me or do I want to do psychoanalysis because that desire to do analysis is rooted in my pathology? I have this strange idea that if there were a genie who could grant me one wish it would be that I be able to do psychoanalysis. That’s an odd fantasy. I mean, most people with emotional problems would just fantasize about the genie clearing up their emotional problems – that would be the ultimate goal. But for me it is the means to that goal that is the object of my wish. It is psychoanalysis itself, doing psychoanalysis, that is my goal. The means to the goal of improved mental health is my ultimate goal. That kind of tells me that my desire for psychoanalysis is not a healthy one, but is actually rooted in my pathology.

That reminds me of something I read about Freud this week. Do you remember last week I was talking about the tightrope walker, that I identified with the tightrope walker. Well, tightrope walking can be an expression of a counterphobia. The person who walks on a high wire might actually be afraid of heights. But he develops a counter-idea to his fear of heights. It’s called a counter-phobia. So a person with a fear
might actually do the exact opposite of the thing that he was afraid of. I looked up counterphobia on Wikipedia and I learned that Freud might have been counterphobic. There was this French psychoanalyst who did a detailed analysis of Freud’s dreams and he concluded that Freud’s entire professional preoccupation with psychoanalysis – his life’s work – may have been an expression of counterphobia. That Freud was actually terrified of facing his unconscious contents and that in his counterphobic attitude he made analyzing his unconscious contents his whole professional preoccupation. So that psychoanalysis could have been Freud’s counterphobia to confronting his own unconscious.

[Didier Anzieu saw Freud’s theorization of psychoanalysis as a counterphobic defense against anxiety through intellectualization: permanently ruminating on the instinctive, emotional world that was the actual object of fear. From a Kleinian viewpoint, Anzieu considered Freud’s “elaboration of psychoanalytic theory ... corresponded to a setting up of obsessional defenses against depressive anxiety”—emphasizing Freud’s need to “defend himself against it through such a degree of intellectualization.”

Klein saw the depressive position as an important developmental milestone that continues to mature throughout the life span. The splitting and part object relations that characterize the earlier paranoid-schizoid phase are succeeded by the capacity to perceive that the other who frustrates is also the one who gratifies. Schizoid defenses are still in evidence, but feelings of guilt, grief, and the desire for reparation gain dominance in the developing mind.

In the depressive position, the infant is able to experience others as whole, which radically alters object relationships from the earlier phase. “Before the depressive position, a good object is not in any way the same thing as a bad object. It is only in the depressive position that polar qualities can be seen as different aspects of the same object.” Increasing nearness of good and bad brings a corresponding integration of ego.

One defense against depressive anxiety is a psychic retreat into a reduced and apathetic state of diminished feelings.]

PATIENT: I think that maybe the same type of thing is going on with me. That my obsession with psychoanalysis is actually a counterphobia: that I am obsessed with psychoanalysis because I am actually terrified of confronting my own unconscious contents.
THERAPIST: Would you believe me if I told you that I had that same idea about you?

[In point of fact, I didn’t entirely believe the therapist. It seems to be a routine part of the therapist’s work with me that she will claim priority for my ideas. This has occurred in several past sessions. I will state an idea and she will respond: “I was thinking the same thing.” It’s possible that my thinking and the therapist’s thinking at times run along the same lines, but at the same time, in my twenty-five years of therapy I have never had a therapist claim priority with such frequency – or at all.]

PATIENT: I suppose it’s plausible.

THERAPIST: What I was thinking about was the case of Marsha Linehan. She developed DBT [dialectical behavioral therapy] for the treatment of borderline disorder. She herself was borderline. So she developed a treatment to help her cope with her own personality problems. When you were talking about Freud’s work on psychoanalysis I was thinking of Marsha Linehan.

[And the therapist seems put off by my intellectualizations? Doesn’t the therapist’s intellectualization at this juncture – her apparent competition with my ideas – suggest envy of my thinking? Kernberg writes that competitiveness can be seen as a defense against unacceptable feelings of envy.]

PATIENT: I just remember that I was left to my own devices as a child. My parents ignored me.

[Again we see the emergence of the idea of being left alone, like the infant being “abandoned” after feeding by mother.]

My parents never bothered to play with me or interact with me, as far as I remember. There’s an anecdote that I remember that impresses me with how much I felt ignored. My father was addicted to the newspaper. He would come home from work with a newspaper every night, then spend the entire evening reading the paper – till maybe 9:00 or 9:30 every night. He would literally read every single article in the newspaper. [My self-absorbed father] ignored me. My mother would read the newspaper too in the evening.

[Significantly, the therapist failed to see the connection with infant feeding. The infant is “abandoned” to his crib after feeding. In this anecdote I am talking about being “abandoned” after dinner – that is, after feeding.]
PATIENT: I remember that one time there was a newspaper strike and there was no daily newspaper for about a week. And I got to interact with my parents. I loved that. I loved the fact that my parents were forced to interact with me because there was no newspaper.

THERAPIST: How old were you at that time?

PATIENT: Maybe 7 or 8 years old.

[Greenacre believed that potentially creative children are less vulnerable to inadequate nurture than we might predict because, as a result of early involvement with some aspect of the external world that they experience with admiration or even awe, they are already relatively independent of their parents. Gedo confirms Greenacre’s claim that individuals destined to become creative are relatively less vulnerable to the vicissitudes of their upbringing than are other children. Gedo, J.E. *The Artist & The Emotional World: Creativity and Personality.*]

Were my feelings about being ignored by my father in latency a derivative of the type of infantile experience that Kohut found in his patient, Mr. U? In early childhood, turning away from the “unreliable empathy” of his mother – she would become overly involved with him, caressing him and meeting his wishes, and then suddenly withdraw and become unresponsive – Mr. U. had tried to gain “confirmation of his self” through an idealizing relationship with his father. The “self-absorbed” father, however, unable “to respond appropriately,” “rebuffed his son’s attempt to be close to him, depriving him of the needed merger with the idealized self-object and, hence, of the opportunity for gradually recognizing the self-object’s shortcomings.” Cowan, J.C. “D.H. Lawrence, Idealization, and Masculine Identity” and Summers, F. *Object Relations Theories and Psychopathology: A Comprehensive Text.*

In adulthood, Mr. U sought out idealized substitutes for the father who rebuffed him. He “remained fixated on two sets of opposite responses to ideals – responses he repeated again and again.” “He either felt depressed and hopeless vis-a-vis an unreachable ideal, or he felt the ideal was worthless and that he, in grandiose arrogance, was vastly superior to it.” “These swings in Mr. U’s self-esteem were an outgrowth of his not having achieved the gradual and thus secure internalization of the idealized parental imago.”

Note that the therapist is consistently oblivious to my relationship with my father. She is exclusively concerned with the breast mother. Loewald pointed out the father’s role
as a bulwark against a child’s fear of maternal engulfment and Jacobson pointed out the importance of the father as offering the child proof that one could be a different being from the mother. Herzog coined the phrase “father hunger” for his report on treating 12 toddlers whose night terrors revealed their need for their absent fathers.

Importantly, for me, the Ideal Other is a fused or composite imago. The Ideal Other is both (2) the hallucinated breast of infancy (an ideal substitute for the spurned real breast endowed with guilt: a manic defense against loss) as well as (2) a derivative of the ideal father (a defense against the engulfing mother). I propose that persons such as Dr. Palombo and Craig Dye or Dr. [redacted] personify that fused imago. See Akhtar, S. Three Faces of Mourning (manic defense involves the reversal of depressive feelings, a way of avoiding sadness and mourning).

PATIENT: Now, as an adult I go to the library.

[This association may be related to the last association to my self-absorbed father who was obsessively preoccupied with his newspaper. In fact, I read the newspaper every day in the library for hours at a time.]

PATIENT: Sometimes I see mothers taking their kids to the library. I feel sad when I look at them. My mother never took me to the library when I was a kid. I think I wish I was one of those kids whose mothers took them to the library.

[The precise import of this reference is obscure. Am I talking about a wish for closeness with my mother, that is, am I talking about anaclitic concerns, or am I talking about my mother’s failure to respond to me as an independent other who might have an interest in the world of the mind that a library represents? Cf. Palombo, S.R. “Day Residue and Screen Memory in Freud’s Dream of the Botanical Monograph.” J. Am. Psychoanal. Assoc. 36(4): 881-904 (1988) (Freud’s writing recapitulated a series of Freud’s earlier conflicts concerning his father and the power of books).

Because of the therapist’s anaclitic concerns she later focused exclusively on the theme of longing for the mother in this anecdote, ignoring other possible meanings suggested by the context of the association – the absence of a mother who loved books, reading, and intellectual things and mother’s failure to recognize me as an independent other who might wish to develop along lines separate from mother’s narcissistic preoccupations. It is significant that my mother used to say proudly, “I hate books!”]
What about the transference implications of this anecdote? When I talk wistfully about my mother’s failure to take me to the library, am I not also talking about the therapist’s failure to respect my inner world and allow me to develop a therapeutic narrative based on free association separate from the therapist’s narcissistic intrusions – her insistence that I focus on anaclitic, interpersonal concerns? In terms of my earlier reference to the emotional world of the creative infant am I not saying that what I regret is not closeness to the real breast but the real breast’s estrangement from the hallucinated breast of my imagination (as symbolized by the world of books – or the library as repository of fantasy).

I am reminded once again of H.G. Wells’ *The Time Machine*. The Time Traveler leaves the world of our time (the real breast) and travels to a phantasmagorical epoch in the distant future (the hallucinated breast). He is tormented by the idea that when he returns to his own world (the real breast) he will be unable to make his experiences in the phantasmagorical world (the hallucinated breast) credible to his peers (the real breast). Is Wells symbolically voicing a regret about the estrangement of the hallucinated breast from the real breast – his need to merge his inner world with his outer world? Were these concerns in fact not the driving issue in my statement: “My mother never took me to the library (the repository of fantasy).” That is, I was distressed that the real breast was utterly estranged from the hallucinated breast of my imagination? These concerns have nothing to do with an anaclitic longing for mother.

This reminds me of something that happens often with many people. A person will have a beautiful dream and want to share it with others. But nobody else cares. Only the dreamer cares about his “beautiful dreams.” Only the infant cares about his hallucinated breast – no one else. Did Freud not want to share his “beautiful dreams” with the entire world? Is that not one message of *The Interpretation of Dreams*? Cf. Palombo, S. R. “Day Residue and Screen Memory in Freud’s Dream of the Botanical Monograph.”

The therapist missed all of this! She doesn’t care. She has no interest in entering my inner world of fantasy. “She had no interest in taking me to the library.”]

PATIENT: I want to tell you about something else. You know while I talk to you each week I am happy with the work we do. As I am sitting here I think, “Maybe this week I won’t write a letter.” As I leave your office and I am walking toward the Metro station I think, “There’s nothing to write a letter about this week. This was a good session. I won’t need to vent in a letter.” But then maybe later, maybe the next day, I start to
think about all my dissatisfactions with the session. And I end up writing a letter. It’s amazing that this progression happens every week in the same way. I think the issue is your seductiveness. You are a seductive person and while I am with you I lose sight of the fact that I have serious problems with you because I am seduced by your personality.

You know it reminds me of a vacuum cleaner salesman. He comes to your door. He makes this incredible sales pitch. At first you think, “I have no interest in buying a vacuum cleaner.” But he is so seductive that you lose your misgivings and you give in to the allure of his salesmanship. You buy a vacuum cleaner. Then, the next day, you use the vacuum cleaner and it doesn’t work the way the salesman promised. It was a seduction. You were seduced.

I wonder about my motivation in writing letters. I see two possibilities. Maybe I am happy to see you and when I leave the office I am angry about being separated from you and I write disgruntled letters that have their origin in my anger about separation. The other possibility is that you are very seductive and while I am here I lose sight of your shortcomings. But when I leave, the seductive allure wears off [and I can see clearly how my satisfaction with you was simply that I was buying into your illusions].

THERAPIST: Earlier you talked about your aunt as if you saw her as a seductive person. I’m not saying that in a sexual way, but you saw her personality as seductive.

PATIENT: Yes, she was a sorceress! She was like a cult leader. There is a relationship to the way I see you. I had earlier said that I thought you were group oriented. Someone once said that there is a relationship between cult leaders and the cult followers. That a good cult leader will make a good cult follower and a good cult follower will make a good cult leader. My perception of you as very group oriented fits in with my perception of my aunt as being a cult leader.

[In fact I was not referring to anything I had read in the psychological literature, but rather to a quote from Thomas Mann’s story, “Mario and the Magician.” Mann wrote: “The capacity for self-surrender, he said, for becoming a tool, for the most unconditional and utter self-abnegation [i.e., for becoming a cult follower], was but the reverse side of that other power to will and to command [i.e., for becoming a cult leader]. Commanding and obeying formed together one single principle, one indissoluble unity; he who knew how to obey also knew how to command, and conversely; the one idea was comprehended in the other, as people and leader were comprehended in one another.” Kernberg and other group theorists point out that a
group of dependent persons who come together to form a dependency basic assumptions group will draft as its leader the most narcissistically-disturbed member of the group. That is, the leader is drafted out of the group of followers.

It’s interesting that the word sorceress has at least two connotations: a seductress (referring to sexual allure) but also a magician (referring to the magician’s power to create illusions).

Significantly, I had talked about my aunt in connection with Thomas Mann’s story, Mario and the Magician at the therapy session on September 18, 2017:

Back to my aunt, the illusion of power is a form of power. The power of the magician lies in his illusion of power. The psychoanalyst Jeffrey Masson addresses this issue in his paper, “Buried Memories on the Acropolis: Freud’s Response to Mysticism and Anti-Semitism” International Journal of Psychoanalysis, 59: 199-208 (1978). Masson cites Thomas Mann’s short story Mario and the Magician as the model of a seductive and manipulative individual – like the cult leader, mystic, or guru – whose hold over another individual or group is predicated on the illusion of power. Mario and the Magician is the story of a mystical demagogue’s attempt to keep his hold over a mountain community and win the villagers over to his brand of false nature mysticism. The intruder gradually seduces most of the community with his talk of a new mystical union between man and nature, his diatribes against modern technology, and his preaching of the need for scapegoats and a sacrificial victim – who is duly killed as a ritual purification of the village. One aspect of the psychological acuity of Mann’s story is the intimate connection it shows between the holder of the illusion of power (the cult leader) and his victim or scapegoat. It is no mere coincidence that a cult-like family will assign one member the role of scapegoat or victim. The relationship between Mann’s magician and his victim vis-a-vis the community parallels my aunt’s relationship with me vis-a-vis the family as a whole.

I am reminded that Kernberg refers to the narcissistic leader of a dependency basic assumptions group as a merchant of illusions, a kind of magician whose power rests on his ability to soothe others through the use of bland cliches. “Chasseguet-Smirgel expanded on Anzieu’s observations, suggesting that [where individual instinctual needs are fused with a fantastic conception of the group as a primitive ego ideal that can be equated with an all-gratifying primary object, the idealized ‘breast mother’] any group, small or large tends to select leaders who represent not the paternal aspects of the prohibitive superego but a pseudopaternal “merchant of illusions.” A leader of this kind provides the group with an ideology, a unifying system of ideas; in this case, the
ideology is an illusion that confirms the individual’s narcissistic aspirations fusing with the group as a primitive ego ideal—the all-powerful and all-gratifying preoedipal mother.” Kernberg, O.F. Ideology, Conflict, and Leadership in Groups and Organizations. (Do some therapists provide the patient with an ideology, a unifying system of ideas, an illusion that confirms the patient’s narcissistic aspirations fusing the therapist as a primitive ego ideal – the all-powerful and all-gratifying preoedipal mother?)

I view the therapist’s personality (her defenses) as making her an ideal candidate to be a soother: an ideal candidate to serve as an all-powerful and all-gratifying preoedipal mother. It appears to me that the therapist has a powerful fear of not being liked by others. She has a powerful fear of being aggressed on by others and is probably rarely aggressed on by others (perhaps indicated by her utter incomprehension that a patient would be disgruntled enough to write critical letters about her). On one occasion she said to me, “Do you think I don’t like you?” (with the implication, “Is that why you write these letters?”). That is a remarkable thing for a professional person to say to a disgruntled client. Can you imagine James Comey saying to President Trump, “Do you think I don’t like you? Is that why you are firing me?” I believe that the therapist has developed a collection of defenses to ward off aggression: a persistently friendly, engaging, disingenuously ingratiating, soothing and seductive manner. It is a personality armor that conceals a powerful insecurity. In my sessions with the therapist I am seduced by her armor; then later, upon reflection I am faced with the reality of her insecurity and her pre-Oedipal preoccupations.

I am reminded of something about my aunt. My aunt loved food, loved to prepare sumptuous feasts where we would gather on Sunday afternoons. She was an excellent cook and spent the entire afternoon in the kitchen preparing a meal. On such occasions the family literally and figuratively took on the characteristics of what Kernberg calls a “feasting crowd.” “The typical feasting crowd [is] engaged, we might say, in dependent and narcissistic behavior and corresponding[ly] search[es] for a calming, narcissistic, reassuring mediocrity in their leader.” Kernberg at 42. The submissive feasting crowd was my family. The soothing leader of that crowd was my aunt. My aunt was both the preoedipal, all-powerful breast mother – the soother of a group of dependent followers — and the raging phallic mother who inspired fear: an actively castrative figure, stifling her “children” by pre-empting all room for autonomous action.

As I reported to the therapist in my letter about the session on September 18: “I think another source of my aunt’s power was her temper. She had outbursts. They were frightening. I think everybody in the family was afraid of her. I remember one time she
lashed out at my father and he was dumb struck. Nobody wanted to antagonize her because you knew the way she might react. So you were careful to never antagonize her.”

In some sense the therapist and my aunt are comparable figures. The therapist wards off the aggression of others by being a soother. She has a friendly, engaging, ingratiating personality: essentially a defensive armor calculated to negotiate her social insecurity. My aunt warded off aggression by being a both soother and a castrative figure who nobody wanted to antagonize.

THERAPIST: [The therapist embarked on a discussion that seemed to take as a starting point my wistful regret about my mother not taking me to the library when I was a child and my feeling that my aunt was seductive. She seemed to focus on my anaclitic longings and how these longings and needs were not satisfied. I experienced the therapist’s discussion as engulfing, distressing, and offensively cloying. I totally turned off. I stopped hearing what she was saying and, at this moment, I can’t even remember anything she said. She seemed to think she was connecting with my concerns – my need for attunement – and she seemed to expect that I would parrot her thinking and embark on an elaboration of her thinking. In fact, the therapist did not connect with my concerns. What she had done was to cherry-pick my ideas and confer a projective (anaclitic) meaning that deviated radically from a holistic appreciation of the import of my narrative which seemed to center on the need for freedom from an engulfing mother, but at the same time my struggle with issues of guilt, depressive anxiety and mourning – issues that became clear near the end of the session.

The therapist’s comments triggered in me a freewheeling discussion of my desire to escape, my desire for freedom.]

PATIENT: For me psychoanalysis means freedom.

[At this moment the therapist took a sip from her water bottle, as if nervously. It was the only time in the session that she sipped from the bottle.]

PATIENT: The ability to express myself. The ability to let my ideas and associations flow. I started talking today about the creative infant. What did that mean for me? We’ll never know what that meant for me. You got me off track with your comments. I viewed them as intrusive. Psychoanalysis is a train of associations. In psychoanalysis my train of associations following my opening comments would tell us what I meant when
I talked about the creative infant hallucinating his mother’s breast. But now we’ll never know what I meant by that. You got me off track.

[I am reminded of a famous line from Goethe’s Faust: “Du hast sie zerstört / Die schöne Welt!” – “You have destroyed the beautiful world with mighty fist; It crumbles, it collapses! A demigod has shattered it!”]

For me a therapy session is like a creative act. In the creative act, the artist follows his inner line of thinking. When a novelist is writing a novel, he doesn’t confer with others for ideas. Other people’s ideas are an intrusion.

[Weismann believed that the ego functions of conventional persons engaged in work differ from the ego functions of creative persons involved in creative productions. “In ordinary work, the synthetic function works without the dissociative function, and produces established useful solutions. In creative work, the synthetic function is re-enforced by the dissociative function. Their combined functions hold in abeyance the established solutions, thus permitting new, original ones to be synthesized.” Akhtar, S., ed. Good Feelings: Psychoanalytic Reflections on Positive Emotions and Attitudes.

Is it possible that psychotherapy for the creative person is a creative activity in which the creative patient’s synthetic function is re-enforced with the dissociative function; whereas, for the conventional therapy patient therapy is more like “work” in which the dissociative function does not play a role? Might there be identifiable (and possibly significant) differences in the entire approach to therapy by creative versus conventional patients?]

PATIENT: For example what if I was Tolstoy and I was writing Anna Karenina.

[At this moment the therapist looks markedly dejected and dismayed. She seems to curl into herself. She seems to follow what I am saying only out of politeness, but doesn’t seem to have any real interest. Perhaps she viewed my discussion as a repudiation of her and her work. And it was!]

[Note that a certain reading of Anna Karenina is an exquisite parable of both depressive anxiety (which I had talked about earlier in reference to Freud) and the struggles of the artist. The reference to Anna Karenina is not a discursive diversion from the import of the session. Rather a certain reading of the novel serves as an emphatic confirmation of the unconscious concerns that motivated the entire therapy narrative. Anna is torn]
between her ideal lover, Alexei Vronsky and her duty-bound husband, the government official, Alexei Karenin. In a dream sees both men before her:

But in dreams, when she had no power over her own thoughts, her situation appeared to her in all its monstrous nakedness. Almost every night there was one dream that kept returning to her. She dreamed that both of them together were her husbands, and that both lavished their caresses on her. Alexis Karenin was weeping as he kissed her hands, and saying: How wonderful it is now! And Alexis Vronsky was also there, and he was her husband too. And she, astonished that this had used to seem impossible for her, was explaining to them with a laugh that this was far simpler and that now they were both pleased and happy. But this dream weighed on her like a nightmare, and she would wake up terrified.

When we translate this quote into the language of Melanie Klein we have a perfect description of the infant in the throes of depressive anxiety who seeks to merge his image of the “good mother” who gratifies with his image of the “bad mother” who frustrates:

But in dreams, when she had no power over her own thoughts, her situation appeared to her in all its monstrous nakedness. Almost every night there was one dream that kept returning to her. She dreamed that both of them together were her mother. The bad mother who frustrated her needs was here and saying: How wonderful it is now! And the good mother who gratified her needs was also there, and she was her mother too. And she, astonished that this had used to seem impossible for her during the earlier paranoid-schizoid phase, was fantasizing that this holistic appreciation of mother was far simpler and that now both mothers were pleased and happy. But this dream weighed on her like a nightmare, and she would wake up terrified.

But there is more than this. The concept of the depressive position, as originally described by Klein, allows for the possibility to discuss the idea of an internal creative world. Betty, N.S. “Creativity: The Adaptive Aspects of Insecure Attachment.” Essentially, the wish to restore the whole loved object, which the individual believes has been lost because of his own attacks, induces guilt that fuels the wish to make reparations. Id. “This wish to restore and re-create is the basis of later sublimation and creativity (Segal).” Id. According to Segal, as long as depressive anxiety can be tolerated by the ego and the sense of psychic reality retained, depressive phantasies stimulate the wish to repair and restore. Id.
Importantly, Segal made the following critical observation about the link between depressive anxiety and creativity: “I have quoted Proust [– Andre Aciman’s idol, by the way –] at length because he reveals such an acute awareness of what I believe is present in the unconscious of all artists: namely, that all creation is really a re-creation of a once loved and once whole, but now lost and ruined object, a ruined internal world and self. It is when the world within us is destroyed, when it is dead and loveless, when our loved ones are in fragments, and we ourselves are in helpless despair, it is then that we must recreate our world anew, reassemble the pieces, infuse life into dead fragments, re-create life. . . . [T]he wish to create is rooted in the depressive position and the capacity to create depends on a successful working through of it[.]

Segal, H. “A Psychoanalytic Approach to Aesthetics.”

The Tolstoy quote can also be applied to the distress of the adult artist who despairs of merging real and ideal, a derivative of the creative infant’s mental imagery of a dissociated ideal (hallucinated) mother and the real (absent or “lost”) mother.

But in dreams, when she had no power over her own thoughts, her situation appeared to her in all its monstrous nakedness. Almost every night there was one dream that kept returning to her. She dreamed that both of them together were her mothers, and that she could have a relationship with both of them. The real mother was there and saying: How wonderful it is now! And the hallucinated mother [that is, the hypercathexed real mother] was also there, and she was her mother too. And she, astonished that this had used to seem impossible for her had reached her ideal state: a merger of the real mother with the hallucinated mother. But the impossibility of merging the real and the ideal weighed on her like a nightmare, and she would wake up terrified.

This theme reverberated throughout the therapy session. The reference to Anna Karenina was not a diversion from the theme; it was the theme, in a different key with a radically different harmony. The train of associations in the session point to issues of guilt, depressive anxiety, and mourning: simply put, my need to resurrect the lost mother by merging real with ideal. All of this was lost on the therapist.

PATIENT: So I tell you I have this idea for a novel where a woman decides to commit suicide. She decides she is unhappy with her life and she decides to throw herself in front of a train. So you say to me, “Well, maybe you shouldn’t have her commit suicide. Maybe you should have her take a trip to Italy instead.”
[Significantly, this is the third successive session in which I talked about a suicide fantasy. In the two previous sessions I talked about Einstein’s thought experiment in which he thought of a man jumping off a roof (reflecting a possible suicide wish). Even more interesting, in November 1977 when I was 23 years old I had a serious suicide attempt; seven months later, in June 1978, when my mental state improved, I booked a trip to Italy!]

PATIENT: Well, your input would derail my ideas. If I am writing the novel, why shouldn’t I have the characters do what I want them to do? [Why shouldn’t I heed the ideas that come to me?] At the end of it all, what I had my characters do, the way I told my story, has meaning. We can look at the meaning of my story. This is my problem with non-analytic therapy. So often it is the therapist telling me how to think my thoughts, directing my thinking – [wanting me to parrot the therapist’s ideas.]

[Comments by Henle suggest the relationship between free association and creativity: “We cannot get creative ideas by searching for them; but if we are not receptive to them, they will not come. Creative ideas are not, in other words, under our voluntary control; yet they require a certain attitude on our part.” Receptiveness “involves detaching oneself from one’s ongoing concerns and without particular expectations, heeding ideas that come.”

The therapist talked earlier about a concern for evidence-based therapy. What do research studies show about the needs of creative individuals? Behavioral and brain studies suggest that creative people are characterized by a lack of inhibition (Eysenck, 1995; Martindale, 1999), and case studies repeatedly show that creative people describe the creative process as effortless and lacking in deliberation (Csikzentmihalyi, 1996). Coercing a patient to talk about certain issues – forcing the patient to deliberate on certain aspects of his mental contents – may be antithetical to the way the brains of creative people work.]

PATIENT: I remember when I was a kid, we would go on class trips in school. And I hated the guided tours. We would go to a museum and we would get a tour guide who showed us around. We would have to follow his agenda. And I felt so constrained. I felt like a prisoner. I would see other people in the museum and I would long to be one of them, free to follow their own plan.

[“I would see other people in the museum and I would long to be one of them.” This is a striking comment that seems related to my earlier observation: “Sometimes I see mothers taking their kids to the library. I feel sad when I look at them. My mother
never took me to the library when I was a kid. I think I wish I was one of those kids whose mothers took them to the library.” The mother taking the child to the library corresponds to the teacher taking the student to the museum. The context of these statements suggest that what I wanted was the ability to go to the library to explore the library on my own just as, when I was a student, I wanted to be free to explore the museum on my own. My desire to be taken to the library by mother had little if anything to do with my longing for a close relationship with my mother. I was talking about my mother’s failure to expose me to things I might be interested in and might wish to explore. The therapist totally misconstrued my longing for exploration as a desire for attachment. It is a stark instance of the therapist trying to force her projective (anaclitic) concerns into me.

The distress I feel in the face of the therapist’s controlling behavior is reminiscent of the distress the young child will experience in Erikson’s “autonomy-shame” stage of psychosocial development in those cases where mother doesn’t respect the child’s growing need for autonomy. Erikson writes that children between 18 months to three years in age become increasingly independent and want to gain more control over what they do and how they do it. Children in this stage of development often feel the need to do things independently, such as picking out what they will wear each day, putting on their own clothes, and deciding what they will eat. While this can often be frustrating for parents and caregivers, it is an important part of developing a sense of self-control and personal autonomy. Children who successfully complete this stage feel secure and confident, while those who do not are left with a sense of inadequacy and self-doubt.”

With this therapist I feel as if I am being taken on a guided tour of a museum by someone with a limited itinerary.

PATIENT: I remember when I was seeing Dr. Palombo there were two sessions where he said absolutely nothing [or virtually nothing]. He let me express myself. He didn’t intrude with his own agenda. Apparently, he thought that what I was doing was valuable. – Maybe that’s why therapists have a problem with psychoanalysts. [I found that humorous.]

APPENDIX A – ON THE SIGNIFICANCE OF FREE ASSOCIATION

At the outset of the session the therapist didn’t seem particularly interested in my discussion of Weisman’s theories about creativity and the infant’s relationship with mother. Later she appeared to become dejected when I talked in the session about
Anna Karenina. Lo, and behold, these were the very same associations that arose in a letter I wrote to a previous treating psychiatrist in 1993 – twenty-four years ago. The therapist seemed to take a keen interest at one point in something I said about my mother: that I regretted that my mother didn’t take me to the library when I was a child. The therapist focused on that observation as if it were of singular importance and (projectively) imposed a meaning on that anecdote that deviated radically from the import of my many other associations.

In May 1993 I compiled a collection of about 30 pages of quotations from literature and historical texts; they were quotes that I identified with. I thought the document would help my then-treating psychiatrist, Suzanne M. Pitts, M.D. to better understand my personality. I reproduce below the cover letter to Dr. Pitts together with an excerpt from the document. You will see that the document contains the very material I talked about with the current therapist at the therapy session on October 16, 2017; the very same references to the work of Philip Weismann and Anna Karenina. Obviously these seemingly random associations are important to me and the reemergence of these same associations twenty-four years later demonstrates the importance of free association and appreciating the fact that a patient’s associations are unconsciously-determined. This material demonstrates the importance of looking at a patient’s therapy narrative holistically.

May 3, 1993
3801 Connecticut Ave., NW
#136
Washington, DC 20008

Suzanne M. Pitts, MD
Dept. of Psychiatry
GW Univ. Medical Center
2150 Pennsylvania Ave., NW
Washington, DC 20037

Dear Dr. Pitts:

The attached writing is a collection of literary and other identifications that I have randomly collected over the years.

To the extent that I have been able to confer some order and cohesiveness on the various issues and themes suggests that the corresponding issues in my personality
cannot be analyzed independently from one another but only as part of a system. Thus, the notion that I am being surveilled by my former employer (an issue in the writing) cannot be interpreted in isolation from other issues (also discussed in the writing) including my job termination, need for mentoring, isolation of affect, intellectualization, my response to people who are similar to me, difficulties in a group setting, feelings of loneliness, etc.

Also, I suspect that there is a relationship between the peculiar structure of the writing and the content of the ideas expressed (apparently relating to identity).

Sincerely,

Gary Freedman

Thus [Weismann] believed that the future artist, as an infant, had the ability to hallucinate the mother’s breast independently of oral needs. According to him the unusual capacities of the artist “may be traced to the infancy and childhood of the artist wherein we find that he is drawn by the nature of his artistic endowment to preserve (or immortalize) his hallucinated response to the mother’s breast independent of his needs gratifications.”


It was sorely-troubed Masters, spirits oppressed by the cares of life: in the desert of their troubles they formed for themselves an image [Bildness] so that to them might remain of youthful love a memory, clear and firm, in which spring can be recognized.


In some patients who had turned away from their mother, in dislike or hate, or used other mechanisms to get away from her, I have found that there existed in their minds nevertheless a beautiful picture of the mother, but one who was felt to be a picture of her only, not her real self. The real object was felt to be unattractive—really an injured, incurable and therefore dreaded person. The beautiful picture had been dislocated from the real object but had never been given up, and played a great part in the specific ways of their sublimation.
Where a separation is sudden, however, . . . an abrupt defensive internalization occurs prematurely, without the gradual process of bringing together and neutralization of the two sides of the ambivalent feelings. The two sides of the introjects thus internalized (ego-ideal and superego precursor) [have] not been adequately moderated through gradual rapprochement cycles. The result [is] an ego ideal with excessive primitive idealization and a superego precursor with excessive sadistic harshness. Freeman, D. M. A., Foulks, E.F., and Freeman, P.A. (1976) “Ghost Sickness and Superego Development in the Kiowa Apache Male” The Psychoanalytic Study of Society 7:123-171, at 135 (Yale University Press: 1976).

But in dreams, when she had no power over her own thoughts, her situation appeared to her in all its monstrous nakedness. Almost every night there was one dream that kept returning to her. She dreamed that both of them together were her husbands, and that both lavished their caresses on her. Alexis Karenin was weeping as he kissed her hands, and saying: How wonderful it is now! And Alexis Vronsky was also there, and he was her husband too. And she, astonished that this had used to seem impossible for her, was explaining to them with a laugh that this was far simpler and that now they were both pleased and happy. But this dream weighed on her like a nightmare, and she would wake up terrified.

Tolstoy, L. Anna Karenina (1876), at 158 (Bantam: 1981).
At the beginning of the session I opened with a detailed discussion of an interpretation of a dream I had had the previous week. I talked about two related dreams I had had earlier.

Later in the session the therapist said to me, “I don’t know if you’ve ever heard of attachment theory.” I said, “you mean the work of John Bowlby?” She launched into a lecture on attachment theory. She talked for some time.

At another point the therapist noted an issue of dissociation in my thinking and proceeded to give me a lecture on dissociation, “Dissociation is an ego defense in which . . .”

My interpretation is that the therapist was taken aback by my dream analyses, she felt envious and competitive with me and needed to “show her stuff.” (“Maybe people feel they need to prove themselves around you,” she had said at an earlier session.) I believe the lecture on attachment theory that she gave was an act of competition with me motivated by envy.
My evidence for that proposition? In a previous session on June 12, 2017 I opened with thoughts about a dream. Later in the session, the therapist launched into a lecture on brain functioning.

My view is that my dream interpretations aroused feelings of insecurity in the therapist as well as envy and that she used her lecture on attachment theory (and dissociation) as a defense against that insecurity and envy. My speculative interpretation about her reaction to me is based on my understanding of group theory. According to Kernberg group members will react with envy to the autonomous member who exhibits individualized thinking, rationality, and independence. Perhaps it is significant that at the earlier session in June 2017, which seemed to trigger a similar reaction from the therapist, the therapist stated in response to my dream narration: “I feel that you are pulling away from me,” thus seeming to link my dream interpretation to issues of affective autonomy, i.e., my failure to relate to her at an emotional level, as well my individualized thinking. Would it be too tentative to suggest that my affective autonomy and my individualized thinking aroused attachment insecurity in the therapist; did my failure to connect with her emotionally arouse the distress associated with a lack of attachment? Linking attachment theory to psychoanalysis is it possible that the therapist interpreted my independent intellectual frolic (my dream interpretation) as a “pulling away of the breast?”

Melanie Klein saw envy as the fragile infant ego responding to a deprivation of some kind. This deprivation may even be minimal, or momentary (such as a momentary “pulling away” of the breast by the mother). The infant’s envious impulse is to attack, or to spoil the very source (i.e., the breast) that the infant originally relied upon for what was desired. In the infant, the feeling of failed gratification (such as a pulling away of the breast) is experienced as the breast withholding, or keeping for itself, the object of desire. Hiles, D. “Envy, Jealousy, Greed: A Kleinian approach.”

What I pick up from Klein’s conceptualization of envy is the infant’s notion that the mother has something valuable (the breast) and by “pulling back” the mother is not sharing it.

Is Kernberg saying that in groups the autonomous member’s individualized thinking and rationality are things that cannot be shared with other group members, and it is this realization by group members that triggers their envy? Keep in mind that in regressed groups the members have relinquished their autonomy (i.e., their individualized thinking and rationality) in the process of homogenization (or de-individuation); further, homogenization (i.e., loss of individual identity) is a process in the service of “attachment” whereby the group members bond with each other and
with the group-as-a-whole, which Kernberg views as the symbolic breast mother. In this sense “attachment,” or symbiosis with the group-as-a-whole, is antagonistic of thinking, rationality and individuality.

Perhaps we may offer the following generalizations about group behavior: specifically about attachment (which will necessarily involve some degree of homogenization) versus individualized thinking in groups. May we say that individualized thinking and attachment behavior (i.e., group members bonding with the group-as-a-whole) are antagonistic opponents? Individuals can only maintain their individualized thinking when their attachment system is deactivated to some degree. Vice versa, individualized thinking is deactivated when attachment behavior is activated, that is, when the person actively seeks a symbiosis with the group-as-a-whole. These antagonistic behavior systems are dialectically mediated: a group member can only maintain his thinking, his individuality and rationality and thus overcome the symbiosis with the group-as-a-whole, when at the same time he feels he can look to himself as the ultimate source of identity and security. Cf. Kim, S. “Outside Advantage: Can Social Rejection Fuel Creative Thought” (individuals with an independent self-concept will become more creative in the face of social rejection unlike persons with an interdependent self); cf. also, Damian, R. “Creativity and Nonattachment: A Relationship Moderated by Pride” (a sense of pride mediates creativity in nonattached persons).

Again, at the session on June 2017 when the therapist said, “I feel you are pulling away from me,” did she symbolically view me as the withholding breast, which triggered her envy? Did she view my dream narration (my individualized thinking) as antagonistic of attachment?

**SUMMARY OF SESSION ON JUNE 12, 2017 (CONTEMPORANEOUS NOTES)**

A session I had with my therapist on June 12, 2017 aroused angry feelings for me afterwards. I talked about a dream I had had. The dream referred to a former coworker whose father died of a brain tumor.

The therapist said nothing about the dream.

I next talked about the fact that I don’t see myself as a vulnerable person. She didn’t have much to say about this.

I next talked about my feelings of being a spectator in the audience at a play. I feel I have split myself into two parts: the spectator in the audience and the actor on stage. I said I have the sense that my feelings are not authentic — as symbolized by the actor
The therapist had nothing to say about these feelings. She didn’t not relate this metaphor to the dream material. Why did I associate to this metaphor after this dream?

The therapist launched into a lecture on the brain — the primitive emotions (of the amygdala) and the more rational thoughts processed in a different part of the brain. I saw this as defensive intellectualization. I saw it as counter-transference and I suspect that the dream I recounted at the beginning of the session unnerved the therapist. I noted the possibly significant association in the therapist’s mind between my reference to a brain tumor and the therapist’s later lecture on brain functioning. Was the therapist’s lecture on brain functioning an instance of projective identification? (Incidentally, I know about the limbic system. I remember seeing an episode of a PBS series on the brain that was broadcast in the year 2002: The Adult Brain: To Think by Feeling. I still remember Antonio Damasio saying, “Human beings are not thinking creatures who feel. We are feeling creatures who thing.” I always liked that quote because I saw it as validating my disdain for cognitive therapy.)

The therapist talked about the “attachment dance” I engage in. She said that at the previous session (June 5) I seemed to be approaching her emotionally, but at this session I seemed to be pulling away. (Was her lecture about brain functioning not a defensive or intellectualized “pulling away” by the therapist?) After the session I was curious about my metaphor of the man at the theater. What was I talking about in psychoanalytical terms? My research disclosed that what I was talking about was depersonalization, that is, a dissociative symptom.

Further research showed that depersonalization is a symptom of trauma — and this is startling — these symptoms are, in fact, related to disorganized attachment. Did my dream relate to dissociation and attachment problems?

What made me angry was that the therapist was unable to identify my metaphor about the theater as depersonalization (a trauma symptom) — and, significantly, failed to see the relationship between depersonalization and attachment problems, despite the fact that she fancies herself an expert in attachment. She has referred to my “attachment dance” on three separate occasions. Does she have a depth understanding of attachment problems? That’s debatable.
In general there was no sign that the therapist was trying to reach or establish contact with my affects; she showed no signs of being “tuned in” on my feelings; on the contrary, she seemed to play along with my intellectualized defensiveness, at those moments I was perhaps defensive — giving a lecture on brain functioning.

It is as if the therapist shows a tendency to elicit defensiveness from me. At one point I had talked about a patient I identified with in something I had read and the therapist proceeded to ask me how I thought the said patient might react had his therapist said certain things. Clearly, the therapist was trying to elicit my projections. At another point the therapist appeared to elicit my intellectualization by talking about brain functioning. In just one session the therapist tried to elicit defensive projection and defensive intellectualization. What is the counter-transference meaning of these behaviors by the therapist.

The Therapist’s Internal Working Model as Revealed in the Countertransference

My therapist sees her theoretical orientation as relational. She views personality problems as arising from disturbances in the child’s early attachment to the mother. She seems to see her role as providing the patient a corrective emotional experience. According to Bowlby the infant’s relationship with mother imprints the child with working models of relationships that come into play in later life. My therapist pays lip service to that premise, but I am concerned about the extent to which her view of attachment theory is simply a projection or rationalization of her own problematic unconscious working model. My therapist’s therapy work reminds me of Bion’s observations about regressed groups; in a regressed group the members use the conscious work task to defend against their unconscious anxieties. Does my therapist use the rational work task of therapy (as well as a simplistic view of attachment theory) to defend against unconscious anxieties? Put another way is the therapist attempting to impose her internal working model onto me?

Under attachment theory, a major goal in psychotherapy is the reappraisal of inadequate, outdated working models of self in relation to attachment figures, a particularly difficult task if important others, especially parents, have forbidden their review. As psychoanalysts have repeatedly noted, a person with inadequate, rigid working models of attachment relations is likely to inappropriately impose these models on interactions with the therapist (a phenomenon known as transference). The joint task of therapist and client is to understand the origins of the client’s dysfunctional internal working models of self and attachment figures. Toward this end, the therapist can be most helpful by serving as a reliable, secure base from which an
individual can begin the arduous task of exploring and reworking his or her internal working models. Bretherton, I. “The Origins of Attachment Theory: John Bowlby and Mary Ainsworth.” Developmental Psychology (1992), 28, 759-775. In attachment based-therapy it appears that the essential component is not simply the corrective emotional relationship of client and therapist, but also the therapist’s and client’s growing intellectual insight into the nature of the client’s internal working model in all its complexity and sophistication, i.e., involving not only the client’s earliest reaction to maternal absence but also later developments between mother and child and third parties.

I have looked at three areas of the therapist’s personality that seem to offer clues about the nature of her unconscious internal working model. I have looked at (1) the anxieties she expresses in relation to me (such as her apparent envy and her unusual distress surrounding my letter writing) which seem to reveal some type of insecurity; (2) the things that the therapist projects onto me (such as the notion that if I am unhappy it necessarily means that I have lost a significant relationship); and (3) her simplistic and distorted notions about attachment theory.

Here are some essential features of the therapist’s representations about attachment theory which seem to disclose an unconscious schema relating to attachment:

1.---The mother is good and desirable. When the mother is absent the child experiences distress.

(Is the therapist saying that any adaptation to an absent attachment figure is pathological — what about the child’s secure base for exploration: where does that fit into the therapist’s formulation? Also, the nursery situation the therapist describes is only one element that goes into the formation of a person’s internal working model. The infant’s internal working model grows increasingly complex and sophisticated with maturation and comes to encompass three-party relationships between child-mother-others, such as father or siblings.)

(Note the identity of this formulation with oral concerns, namely, “food is good and desirable and when food is absent the individual experiences distress in the form of hunger.” It is perhaps instructive to note that fantasy is inadequate to moderate hunger, but thoughts can adaptively moderate psychological distress. I am not simply talking about dissociation, but the ego functions of active imagination or capacity for fantasy associated with the trait “openness to experience” sometimes associated with
higher intelligence — capacities that seem grounded, in the language of attachment theory, in the child’s secure base for exploration.

There is a suggestion of splitting and idealization in the therapist’s thinking: Is the therapist saying, “the present mother is the good mother; the absent mother is the bad mother?” What about the possibility that the present mother is frustrating or that the absent mother permits exploration? According to the psychoanalyst Rhona M. Fear, there is circumstantial evidence that Bowlby himself had attachment anxieties and that his theory grew out of an idealized worldview: “Bowlby’s ideas, perhaps, are the result of his disappointment with a mother who possibly did not give him what he most craved and his resentment towards her due to her favouritism of his brother, Tony. Maybe his belief that women should be the carers was the result of an idealised view of reality.” Fears, R.M. Attachment Theory: Working Towards Learned Security.

While initially empirical observation focused on the infant’s acute distress when separated from the mother, as expressed by protest, despair and detachment, extensive evaluation of Bowlby’s hypothesis of maternal deprivation by Rutter in the 1970s and 1980s suggested that a far more complex set of social and psychological factors were in operation. As Holmes points out, Rutter’s work prompted a move away from a simplistic event-pathology model to an appreciation of the subtle nature and quality of the child’s attachment to the mother or primary caregiver. Renn, P. “Psychoanalysis, Attachment Theory and the Inner World: How Different Theories Understand the Concept of Mind and the Implications for Clinical Work.”

2.---The father has no psychological significance.

(The therapist majored in gender and women’s studies and wrote a master’s thesis on child sex molesters, i.e., a topic that emphasizes a view of men as sexually predatory). (Ann Daly has pointed out that “Bowlby’s work resulted in an idealization or over-idealization of motherhood and influenced a movement toward the intense sole dyadic relationship of mother and baby.” Reale, K.A. “Get a Grip: How a Psychotethapist’s Postpartum Depression Disrupted the Illusion of the Idealized Mother and Changed Forever What It Means to ‘Hold’.” Cf. Blos, P. “Freud and the Father Complex.” (“The role of the early father was that of a rescuer or savior at the time when the small [male] child normally makes his determined effort to gain independence from the first and exclusive caretaking person, usually the mother. At this juncture the father attachment offers an indispensable and irreplaceable help to the infant’s effort to resist the regressive pull to total maternal dependency, thus enabling the child to give free rein to the innate strivings of physiological and psychological progression, i.e., maturation.”)
Bowlby himself wrote the following: “No variables . . . have more far-reaching effects on personality development than have a child’s experiences within his family: for, starting during his first months . . . in his relations with both parents, he builds up working models of how attachment figures are likely to behave towards him in any of a variety of situations; and on those models are based all his expectations, and therefore all his plans, for the rest of his life.”

3.---Internal object development is irrelevant.

(At a recent session I said I was depressed. The therapist responded, “I note that you got a new case manager,” linking my depressed mood to the loss of my old case manager. I pointed out that I had recently completed a book I was writing and experienced the completion of my activity as a loss that triggered a depressed mood. The therapist was unable to envision that depressed mood (distress) can be a result of inner concerns and is not necessarily anaclitic, or a reaction to loss of a relationship. Thus, in the therapist’s mind “The mother is good and desirable. When the mother is absent the child experiences distress” but also the following fallacious corollary: “If child is distressed it is because mother is absent.”)

4.---The child has no self-soothing abilities and will necessarily be distressed in mother’s absence.

If that were true it is doubtful that Bowlby would have viewed transitional objects (blankets, stuffed animals and such) as a healthy part of child development in line with Winnicott. But in fact Bowlby considered transitional objects a healthy “substitute” for the absent mother, and he deemed the child’s attachment to them normal and even desirable (in distinction to previous analysts who regarded transitional objects as a childhood fetish reflecting pathology in the relationship between the mother and her child). Thus, the correct formulation is “When mother is absent, the child may self-soothe with transitional objects” and not “When mother is absent, the child is distressed.”

5.---Maternal absence does not promote autoplastic adaptation in the form of internal object development (with the possible implication, “because maternal absence is bad nothing good can come of it” with its suggestion of black and white thinking associated with paranoid schizoid anxiety).

What does the therapist’s apparent internal working model say about her personality and her own attachment style according to attachment theory? What does her use of
selected fragments of attachment theory — her cherry-picking of features of attachment theory (possibly to serve her own need-satisfying objectives) — say about her unconscious anxieties?

There’s a possibly revealing issue in the therapist’s overly-reductionist approach in which she keeps drawing back to an internal working model based on infantile experience, or an event-pathology model. Attachment theorists believe that attachment-type relationships form during the early months of life, and become increasingly more complex and sophisticated during the process of development towards adult maturity. These relationships develop around a child’s needs for protection from danger and for comfort when they are feeling distressed. They also depend on the response that the expression of these needs elicits in the child’s caregivers. In focusing on infantile experience doesn’t the therapist express her need to turn away from childhood trauma and return to a nursery world where mother was always comforting when present, there was no need for mother to defend the child against dangers from the environment or third parties, and the only distress in life was associated with mother’s absence? See Purnell, C. “Childhood trauma and adult attachment” (discussing childhood trauma and the development of a dismissive avoidant attachment style in adulthood).

It is important to keep in mind that the putative internal working model I have worked up for the therapist is not necessarily conscious to the therapist. “Bowlby allowed for the possibility of multiple internal working models, one relatively accessible to consciousness and one ‘relatively or completely unconscious,’ that may conflict with each other. It is clear that Bowlby views the unconscious working model as an accurate representation of actual events in contrast to the conscious working model which is often the distorted product of defense.” Eagle, M.N. Attachment and Psychoanalysis: Theory, Research, and Clinical Implications. What I am saying is that the therapist’s apparent secure social relations in the real world may defensively conceal unconscious attachment insecurities — unconscious insecurities that may become particularly prominent in the face of the regressive pull of the therapy setting.

**MISCELLANEOUS THOUGHTS ABOUT ATTACHMENT THEORY I SENT BY EMAIL TO PHILLIP R. SHAVER, PH.D., UNIVERSITY OF CALIFORNIA AT DAVIS (NOVEMBER 19, 2017)**

Dr. Shaver is a leading researcher in the field of attachment theory.

Dr. Shaver:
May I share with you this layman’s thoughts about Bowlby and attachment theory? A major flaw in Bowlby’s attachment theory is that it fails to account for the uniquely human aspect of the human animal. Bowlby tried to link human development to biology and looked to ethology (the study of animal behavior) as a model for human psychology. The problem is that chimpanzees or wolves can’t write Hamlet, listen to Beethoven, enjoy baseball, or create civilization — all issues that occupy psychoanalysis, whose preoccupation with the internal world of fantasy is dismissed by Bowlby. See Mattson, M.P. “Superior pattern processing is the essence of the evolved human brain.” Front. Neurosci. 2014; 8: 265 (2014) (while human babies may resemble chimpanzee babies in behavior, humans’ capacities for reasoning, communication and abstract thought are far superior to other species and gross anatomy of the brains of each species reveals considerable expansion of three regions in humans: the prefrontal cortex, the visual cortex, and the parietal—temporal—occipital juncture).

If you look only at the intersection of the human and the animal, you end up with the central red area of a Venn diagram, but what about the rest of the circle? People say, “attachment theory” has a scientific basis that psychoanalysis lacks. What scientific models can explain Hamlet, Beethoven, baseball — or human civilization? It’s a ridiculous argument.

Do chimps and wolves, two social species, have a desire for individuality and autonomy comparable to that found in humans? There are limitations to the use of ethology to understand the importance and adaptive value of human strivings for individuality and autonomy — not to mention the adaptive value to humans of having a rich inner world of fantasy. See, e.g., Advances in the Study of Aggression, Volume 2, edited by Blanchard, R.J. and Blanchard, D.C. (London: Academic Press, 1986) (There is empirical and theoretical interest in the direction of understanding the functional or adaptive value of fantasy activities. Why do individuals dream, daydream, engage in imaginative play, write dramas, or go to the theater? What adaptive value do these activities — all transformations of intrapsychic fantasy, or psychic reality — have?). See also, Palombo, S.R. Dreaming and Memory: A New Information-Processing Model (New York: Book World Promotions, 1978) (dreams serve an information-processing function by matching present and past experience in determining what information will be filtered through for storage in permanent memory).

Also, can mental functioning be reduced to simply issues of attachment and the child’s registration of objective reality, without consideration of the (adaptive and maladaptive) role of psychic reality (dreams, fantasies, wishes and desires) in refashioning objective reality? (Bowlby once famously said of psychoanalysis: “I think that’s all rubbish, quite frankly.”) Creativity in science is rooted in unconscious fantasy. It
has been found that the creative scientist shows a preference for irregularities and disorder, he temporarily takes leave of his senses, permitting expression of unconfigured forces of his irrational unconscious (an irrational unconscious whose dynamic power is denied by Bowlby). Boxenhaum, H. “Scientific creativity: a review.” *Drug Metab. Rev.* 23(5-6):473-92 (1991).

Attachment theory posits that human beings have an innate biological drive to “seek proximity to a caregiver in times of alarm or danger”. We’re “hardwired” – programmed in our brains – to “attach” to someone for physical safety and security. Attachment theorists like to point out that research has proven this hypothesis beyond irrefutability and prioritizes it even over the drive for food. This hardwired attachment behavior becomes a powerful ally in the healing process in therapy; clients can use the therapist as an “attachment figure” to experience safety, protection, a “secure base” in times of alarm or perceived danger and, over time, internalize that secure base within themselves.

How do attachment theorists reconcile their view of mental health — a view that emphasizes healthy dependence on the mother as primary attachment figure and on social relations and groups in adulthood — with the functioning of creative persons who place a premium on autonomy, emotional detachment, independence of thought and behavior, and a reliance on the self as the ultimate source of identity and security? Research shows that even in childhood the potentially creative child show unusual autonomy from his parents.

In studies many creative subjects indicated that as children they had enjoyed a marked degree of autonomy from their parents. They were entrusted with independent judgment and allowed to develop curiosity at their own pace without overt supervision or interference. Donald MacKinnon noted of these parents, “They did not hesitate to grant him rather unusual freedom in exploring his universe and in making decisions for himself — and this early as well as late. The expectation of the parent that the child would act independently but reasonably and responsibly appears to have contributed immensely to the latter’s sense of personal autonomy which was to develop to such a marked degree.”

But this autonomy has been shown to have a darker side — it coexists with a certain emotional detachment from one or both parents. According to attachment theorists emotional detachment is a mark of insecure attachment and fear of rejection. In one study creative subjects often reported a sense of remoteness, a distance from their elders — i.e., markers of insecure attachment dating back to infancy — which ultimately helped them avoid the overdependence — or momentous rejection — that
often characterizes parent-child relationships, both of which were believed to interfere with the unencumbered unfolding of the self through the creative process.

In a study of eminent scientists Anne Roe found that many subjects had quite specific and fairly strong feelings of personal isolation when they were children (suggestive of insecure attachment). They felt different, or apart, in some way. Such statements as the following from physicists, in particular, were strong: “In college I slipped back to lonely isolation.” “I have always felt like a minority member.” “I was always lonesome, the other children didn’t like me, I didn’t have friends, I was always out of the group. Neither the girls nor the boys liked me, I didn’t know why, but it was always that way.”

In a study of architects MacKinnon found that the least creative showed the following characteristics seemingly associated with secure attachment: abasement, affiliation, and deference (socialization); their goal was to meet the standard of the group (i.e., the attachment figure). MacKinnon, D.W. “Personality and the Realization of Creative Potential.” American Psychologist 20: 273-81, 1965. The most creative architects scored highest on aggression, autonomy (independence), psychological complexity and richness, and ego strength (will); their goal was found to be “some inner artistic standard of excellence.” Cattell found that high ego strength (found in creative persons) was associated with being self-reliant, solitary, resourceful, individualistic, and self sufficient: characteristics seemingly associated with insecure attachment. In creative persons are the characteristics of aggression, autonomy, psychological complexity and richness and ego strength associated with insecure attachment?

How does attachment theory reconcile the fact that although attachment is biologically-driven, the emotional detachment associated with insecure attachment — with its consequent promotion of unusual autonomy and creativity — has survival value for the group?

It is important to keep in mind, as Stephen Jay Gould (1981) has pointed out, that natural selection may produce a feature for one adaptive reason (e.g., the drive for attachment which promotes infant survival and group cooperation in adulthood). However this may have a number of potentially “non-adaptive sequelae” — such as the compromising of individual identity in the drive for group cohesion, the loss of rationality and the development of “group think”, and the (envy-based) scapegoating of independent-minded outsiders who pose a threat to group cohesion, see Kernberg. In short, there is no guarantee that all features of biology are adaptive. From a different perspective, we may also say that individuals who do not conform to biological imperative (e.g., persons with insecure attachment) may have qualities that prove to be biologically adaptive for the group (such as, heightened autonomy, which promotes novel problem-solving skills that have survival value for the group).
Evolution is more complex than Bowlby seems to assume. Positive (good) things can come from negative (bad) things and negative (bad) things can come from positive (good) things.

Gary Freedman
Washington, DC

RESPONSE FROM DR. SHAVER (EMAIL NOVEMBER 19, 2017):

---Original Message---

From: Phillip R. Shaver
To: garfreed
Sent: Sun, Nov 19, 2017 2:10 pm
Subject: Re: SPN Profile Message: problems with Bowlby

Hi. I don’t have time to respond in detail, but you are ignoring the fundamental concept in the theory: “a secure base FOR EXPLORATION.” That was the idea that motivated Ainsworth’s development of the strange situation assessment procedure. So basically you are running wild in a direction that ignores a centerpiece of the theory. Secondly, Tsachi Ein-Dor and some of the rest of us have published several papers showing that people who score fairly high in attach anxiety or avoidance make important contributions to the groups they belong to. The anxious individuals are sensitive to threats and are quick to mention their worries to others (they are also better at detecting bluffing during poker games). The avoidant individuals are quick to see how to save themselves in a threatening situation, and while avoiding harm to themselves often inadvertently save other people by countering a threat or seeing a way to escape, inadvertently showing others how to escape. In one of our studies we found that avoidant young pre-professional singles tennis players have better records than less avoidant players, perhaps because they can hold up better while traveling and competing alone. Aside from all these details, I would say that no one in the attachment field ever claimed that attachment is everything.

Bowlby was primarily focused on infancy, and human infants are more like monkey infants than adult novelists are like adult monkeys. Bowlby was also a clinician, so he was looking at possible early experiences that presaged later mental health problems, later delinquency, etc. In the adult realm, he focused mostly on loss and grief, which is a core process that may be more similar in monkeys and humans than is, say, painting or comedy writing. So, to make the 1000-page 3rd edition of the Handbook of
Attachment, plus thousands of research articles not covered there, short, I think you’re running wild in a direction not much addressed by attachment researchers but not at all incompatible with the theory.

But maybe I would have a more refined opinion if I had time to look into it. I am a 73-year-old retiree and member of my County Grand Jury, so I don’t have much time at the moment to defend Bowlby, who is long dead but clearly made major contributions to science and society. He doesn’t need much defending, especially with respect to what he didn’t write about.

Sent from my iPhone

COMMENTS ABOUT DR. SHAVER’S EMAIL MESSAGE:

Dr. Shaver said something that was remarkably ironic:

“I don’t have much time at the moment to defend Bowlby, who is long dead but clearly made major contributions to science and society. He doesn’t need much defending, especially with respect to what he didn’t write about.”

John Bowlby ridiculed psychoanalysis because of its emphasis on psychic reality, or intrapsychic fantasy. Concerning psychoanalysis he once famously said, “I think that’s all rubbish, quite frankly.” Bowlby is on record as saying that Melanie Klein denied the importance of real relationships.

Morris Eagle writes: “Bowlby[] claim[s] that from the start [the] infant is capable of reality testing rather than having to rely on a complex set of projective and introjective processes in order to ‘construct’ an external world. Th[is idea] may not have been [] explicitly stated by Bowlby. However, I believe that [it is] at least implicit [in] aspects of Bowlby’s general attitude and skepticism toward Kleinian theory.

[Bowlby’s criticism is not] justifiable. The passage cited from [Bowlby’s training analyst, Joan] Rivière in Chapter 1, and Bowlby’s response to it (“role of environment = 0“) notwithstanding, as we have seen in a previous chapter, Kleinian theory does not discount the role of actual events in the development of the child. Although the emphasis on endogenous instincts remains, an assumption of Kleinian theory is that one needs good object experiences in order to modulate hate and destructiveness emanating from the death instinct and to strengthen object love and the life instinct.” Eagle, M. Attachment and Psychoanalysis: Theory, Research, and Clinical Implications
“Role of environment = 0”? Melanie Klein never said that.

Again, Greenberg and Mitchell write: “Real other people are extremely important in Klein’s later formulations. The child regrets the damage he feels he has inflicted upon his parents. He attempts to repair that damage, to make good, over and over again. The quality of his relations with his parents and the quality of his subsequent relations with others determine the sense he has of himself, in the extremes, either as a secret and undiscovered murderer or as a repentant and absolved sinner.” Greenberg, J.R. and Mitchell, S.A. Object Relations in Psychoanalytic Theory at 127 (Cambridge: Harvard University Press, 1983).

To paraphrase Dr. Shaver: I don’t have much time at the moment to defend Melanie Klein, who is long dead but clearly made major contributions to science and society. She doesn’t need much defending, especially with respect to what she didn’t write about.

What I find fascinating about attachment theory is that it makes sense in itself until you start to look at its representations about psychoanalysis. When you need to distort your predecessors’ work to bolster your “science” what does that say about your “science?”

DREAM INTERPRETATION PRESENTED TO THERAPIST ON JUNE 12, 2017:

DREAM OF THE BOTANICAL MONOGRAPH – JUNE 11, 2017

Arnold Zweig (10 November 1887 – 26 November 1968) was a German writer and anti-war and antifascist activist. Zweig had written a book about antisemitism titled Caliban which he dedicated to Freud. Arnold Zweig was an associate of Freud’s.

Stefan Zweig was a writer who collaborated with the composer Richard Strauss on the opera, Die Schweigsame Frau (The Silent Woman). Perhaps Strauss’s most famous opera is Der Rosenkavalier which features a silver rose (a token of love) — the opera takes place in Vienna. Because Zweig was a Jew, the opera was banned by the Nazis.

In January 1991 I was in a car accident and suffered a fractured wrist and head concussion that caused a 2-hour coma (brain issue); I was hospitalized at GW. The doctor was John White, M.D. It was the beginning of the Gulf War in the Middle East. At work the firm (Akin Gump Strauss) sent me a plant or flowers — the sender was not identified. Later that year I was terminated by the firm under cloudy circumstances.
In January 1977 I worked at The Franklin Institute in Philadelphia. In about January 1977 I had given two white roses to a coworker named Sharon White at The Franklin Institute where I was employed, together with a poem I had written. At that time I worked in an office with Silba Cunningham-Dunlop. Her Jewish father (Paul Frischauer), a writer, lived in Vienna (the city of his birth) at that time and had emigrated to Brazil during World War II to escape the Nazis. Silba’s father died four months later, in May 1977 of a brain tumor (astrocytoma — astoria?). The inauguration of Jimmy Carter took place on January 20, 1977. Carter was advised by Bob Strauss—the founder of the law firm where I worked years later, in January 1991.

In 1938 Freud wrote to Zweig from Vienna: “Everything is growing ever darker, more threatening, and the awareness of one’s own helplessness ever more importunate.” (I quoted this in my book, Significant Moments.) In 1977 Silba Cunningham-Dunlop and I worked on a monograph on the carcinogenic properties of ionizing and nonionizing radiation.

June 11 was the birthday of composer, Richard Strauss. That evening, June 11, 2017, I had the following dream:

I am in the living room of the house where I grew up. Although it is daytime, the room is dimly lit. (In fact the room was always dark; the living room had only one small window). Someone has left a floral arrangement on a table. They are deep red astorias. In fact there is no such flower. Someone has left a note attached to the flowers. It says, “Dark forces have overtaken Vienna, but the forces of light will someday return. Farewell, my beloved Vienna.” The note is signed Arnold Zweig. I sense that the note refers to the Nazi takeover of Austria in March 1938. I have the sense that sad events are happening elsewhere, but that I am safe in the living room of the house.

Every student of Freud’s will be familiar with the following dream.

Freud’s Dream of the Botanical Monograph is a short and sweet little ditty that goes a little something like this:

I had written a monograph on a certain plant. The book lay before me and I was at the moment turning over a folded colored plate. Bound up in each copy there was a dried specimen of the plant, as though it had been taken from a herbarium.

Freud’s interpretation of this dream is complex, and he returns to it multiple times throughout The Interpretation of Dreams. The most important symbolic significance
that he teases out of it relates to the meaning of the “certain plant” that he studies in the dream.

Because Freud “really had written something in the nature of a monograph on a plant,” the monograph in the dream reminds him of his work on the coca-plant. So, the “certain plant” in the dream becomes a symbol of Freud’s work on the medicinal properties of cocaine—as well as a symbol of his mixed feelings about that work.

Freud viewed his work on the coca-plant with both positive and negative associations: positive, because he prided himself on having made important contributions to anesthesiology; and negative, because his recommended use of cocaine as a painkiller led to the death of his friend and colleague Ernst Fleischl von Marxow. With this in mind, the symbolic significance of the “certain plant” in the dream doesn’t just relate to the coca-plant itself, but to a whole slew of Freud’s professional ambitions and anxieties as well.

The important fact for me about Freud and cocaine was that Freud had experimented on himself with the substance. The following associations come to mind:

**ADDITIONAL ASSOCIATIONS:**

In the spring of 1965, when I was 11, the following events transpired. I had the idea that I wanted to be a world famous scientist. I wanted to win a Nobel Prize in medicine. My first recollection of the Nobel was in the fall of 1964 (age 10), months earlier. Martin Luther King, Jr. had won the Peace Prize and my mother was incensed: “So now a convict gets a Nobel Prize!” My mother had strong racist convictions.

I had the idea that I would infect myself with poison ivy, a flowering plant, and then find a cure for the resulting rash. I stripped off the leaves of a poison ivy plant and rubbed them all over my face. I came down with a horrible rash and suffered terribly. When I went to school my sixth grade teacher (Olga Kaempfer), fearing that I had an infectious disease, sent me to see the school nurse (Rose Heckman). Mrs. Heckman said I had a poison ivy infection and told me to apply calamine lotion. Thus, my hopes of a brilliant future as a research scientist were dashed! I would be forced to find another road to world historical glory! That road would turn out to involve my relationship with Bob Strauss.

(At age 3 I came down with scarlet fever. Our house had to be quarantined by the Philadelphia Department of Health (scarlet fever = deep red astorias?). This was a
major emotional event from my childhood; the illness, which was blamed on my mother, caused a lot of tumult centering on my mother’s parenting and the embarrassment to my family caused by the Health Department quarantine. The Health Department posted a notice on the front door of our house – a kind of scarlet letter. “You may not enter this premises.”

Freud’s dream of the botanical monograph related, in Freud’s analysis, to his earlier work on cocaine, derived from the coca plant. Like me, Freud had experimented on himself with cocaine. Like me, Freud had a lifelong desire to win a Nobel Prize; he was nominated for 12 years, but the nominations ceased forever when the Nobel committee engaged an expert who said that Freud’s work was of no proven scientific worth.

So my dream seems to relate to my narcissistic need for fame and my idea of experimenting on myself. These issues seem to be at play in my letter writing in which I record and analyze my therapeutic sessions – as if I were doing important scientific work. There is an aspect of dissociation here, or ego splitting, in which I am both the patient suffering from a disorder as well as the scientific researcher investigating that very disorder. In my therapy sessions it is as if I have taken on the role of both the patient undergoing treatment as well as the psychoanalyst analyzing a patient.

DREAM INTERPRETATIONS PRESENTED TO THERAPIST ON NOVEMBER 13, 2017:

THREE RELATED DREAMS

THE DREAM OF THE THIRDS

Upon retiring on the evening of November 6, 2017 I had the following distressing dream. I had had a therapy session with my therapist earlier that afternoon.

I was about to enter my third year of law school. I received a letter from the law school that read: “You have completed only 57% of the course credits required for graduation.” Of course, I should have completed 66% of my course credits. In a panic I thought, “How am I going to squeeze all the courses I need into one year.”

Does the dream reflect my concern about my mortality? Was I really expressing the idea, “How am I going to squeeze all the things I want to accomplish in the remaining years I have?”
The dream reminds me of Erikson’s observations about Freud (Insight and Responsibility).

Freud at times [during the 1890s when he was in his forties] expressed some despair and confessed to some neurotic symptoms which reveal phenomenological aspects of a creative crisis. He suffered from a “railroad phobia” and from acute fears of an early death—both symptoms of an overconcern with the all too rapid passage of time. “Railroad phobia” is an awkwardly clinical way of translating Reisefieber—a feverish combination of pleasant excitement and anxiety. But it all meant, it seems, on more than one level that he was “coming too late,” that he was “missing the train,” that he would perish before reaching some “promised land.” He could not see how he could complete what he had visualized if every single step took so much “work, time and error.”

**Preceding events:**

On the afternoon of the dream (Monday, November 6, 2017) I had a psychotherapy session. I was in a notably depressed mood, especially in comparison with the two previous therapy sessions at which I displayed an almost hypomanic state of excitement. In the two previous sessions I had talked nonstop, without therapist intervention, for 50 minutes. I attributed my depressed state on November 6 to a kind of “post-partum depression.” I told the therapist that I had finished the novel I had been working on since January 2014. I said that I had read that creative people can experience a kind of post-partum depression when they complete a project. I said that I felt the same way in the year 2004 after I had completed my last novel.

The theme of the manifest dream was the three-year law program. Likewise, pregnancy is measured in trimesters from the first day of the woman’s last menstrual period, totaling 40 weeks. The first trimester of pregnancy is week 1 through week 12, or about 3 months. The second trimester is week 13 to week 27. And the third trimester of pregnancy spans from week 28 to the birth. Like law school, pregnancy is a time limited event.

A lifetime is a time-limited event beginning with birth and ending in death. Perhaps, Freud would have been fascinated by this dream as it suggests the riddle of the Sphinx that Oedipus solved. The Sphinx posed the question: What walks on four legs, then two legs, and finally on three legs. Oedipus found the answer to the riddle with ease, replying: “Man, who as a baby crawls on four legs, then walks on two legs as an adult and in old age walks with a cane as his third leg...” That is, the span of a person’s life is divided into three parts. Is this dream Oedipal in some way? Note how I had
previously talked about how I see things I am not supposed to see. I solve riddles I am not supposed to solve. I had linked this propensity to the primal scene and my drive for forbidden knowledge.

Also, in my second year of law school I took a course in constitutional law where we studied the U.S. Supreme Court decision in Roe v. Wade, the landmark abortion ruling that framed the pertinent legal issues in terms of the trimester format.

A psychotherapy session is a time-limited event confined to a 50-minute period. At a previous therapy session I struggled with the issue of whether or not it is appropriate to begin a session with material that had been left unsaid at the end of the previous session.

I had said to the therapist: “Last week, at the end of the session, I wanted to mention an anecdote and you stopped me. You said we had run out of time. You suggested that I could talk about the anecdote at the next session. Well, you know I’m an obsessive person and I obsessed about that issue in a philosophical way for the last week. Should I tell you what I wanted to tell you last time, or leave it unsaid? I’m inclined not to tell you the anecdote I wanted to mention last time. A therapy session should be “in the moment.” This week I should begin talking about what is on my mind this week, and not what I wanted to say last week but didn’t get a chance to say. I struggled with that issue. I was thinking of something. You know when a young person dies, maybe he’s 30 years old — he’s married and has young kids and people will say, “He was so young. He’ll never get a chance to see his kids grow up—get married, have kids.” But another way of looking at it is: he lived the life that he lived. That was his life. He did what he did. That was his life. It’s like a composer, maybe he dies young and maybe he could have gone on to write all kinds of great music, but he wrote what he wrote in his lifetime and that’s it. He’s judged based on what he wrote in his lifetime. When Beethoven died, that was it. There was no next session for Beethoven. There was no continuation for him to say what he wanted to say. He died when he died, and that was it. He wrote what he wrote. I’m thinking maybe a therapy session is like that. A narrative is what it is and when the 50 minutes are done, that’s it. The next session, you start anew based on what’s on your mind the next week. You begin a new narrative. The old narrative is what it is at the end of the 50 minutes. That’s it. Therapy is not a debriefing. It’s not me telling you the story of my life. It’s about what is on my mind in the moment.”

The reference in the dream to the number 57 is possibly significant. Beethoven died in his 57th year. The following is a related dream I had about Beethoven, four years ago.
The dream concerns my anxieties about Beethoven reaching the end of his life, the end of his creative lifespan. There was no “next session” for Beethoven.

A significant issue that links Beethoven to the manifest dream is the fact that Beethoven’s creative output is measured in three periods. The first period was imitative; he followed the models set down by his teachers, Mozart and Haydn. The second period is the so-called heroic period in which he came into his own. The last period, the third period, is marked by extreme originality and profundity.

Anthony Storr writes about Beethoven’s work: Beethoven’s creative output has been famously described as tripartite, with an early, middle, and late period. Actually, according to some psychologists, the work of all artists (artists worthy of the name artist, at least) typically passes through three phases, provided they live long enough. Third period works have certain characteristics. First, they are less concerned with communication than what has gone before. Second, they are often unconventional in form, and appear to be striving to achieve a new kind of unity between elements which at first sight are extremely disparate, Third, they are characterized by an absence of rhetoric or any need to convince. Fourth, they seem to be exploring remote areas of experience which are intrapersonal or suprapersonal rather than interpersonal. That is, the artist is looking into the depths of his own psyche and is not very much concerned as to whether anyone else will follow him or understand him.

A striking issue is that I had the dream about Beethoven in December 2013, weeks before I started working on the novel I began on January 1, 2014, the novel whose completion had possibly triggered my depressed mood on November 9, 2017, my so-called “post-partum depression.” What does that mean?

The Dream of Beethoven

After I retired on the evening of Thursday December 12, 2013 I had the following dream about the German composer, Ludwig van Beethoven. I had had a therapy session with my psychiatrist earlier that afternoon.

Beethoven and I are alone in a room. We talk about music. I feel awe, enthrallment and narcissistic elation talking to Beethoven. I ask him what he plans to write after the series of string quartets he’s working on. I feel sadness because I know that in fact Beethoven died after he completed his late string quartets. I know that he will not write any more music. He tells me that he has not decided what he will write after he completes his series of quartets. He tells me that he will never write another symphony,
piano sonata, or string quartet. I suggest that maybe he will write something in variation form. He says, “perhaps.” He then launches into a long technical discussion about the variation form. I don’t understand anything that he says but I listen with keen interest. I then said, “People say that every musical form you tackle, you seem to exhaust. Your compositions are such a comprehensive statement in every form you write in that you leave nothing for the composers who will follow you. You say everything there is to say.” Beethoven responds, “I have heard that. I don’t believe it. Composers who come after me will write symphonies, piano sonatas and string quartets.” (Beethoven was deaf from about the age of 35 onward).

EVENTS OF THE PREVIOUS DAY:

1. I have a session with my psychiatrist in the late afternoon. I attempt to say something about Beethoven (“Sunday is Beethoven’s birthday”), but the psychiatrist cuts me off, “Maybe we’ll get to that later.” Perhaps my feeling of being cut off by the psychiatrist corresponds to Beethoven dying relatively young at the age of 56. Beethoven’s life was cut short before he completed his life’s work, while he still had something to say.

I spent the session with my psychiatrist talking about the issue of narcissistic elation. “Narcissistic elation” was a term used by Béla Grunberger to highlight ‘the narcissistic situation of the primal self in narcissistic union with the mother’. The term was coined to describe the state of prenatal beatitude, which according to Grunberger characterizes the life of the fetus: a state of megalomaniaclal happiness amounting to a perfect homeostasis, devoid of needs or desires. The ideal here is bliss experienced in absolute withdrawal from the object and from the outside world. Narcissistic elation is at once the memory of this unique and privileged state of elation; a sense of well-being of completeness and omnipotence linked to that memory, and pride in having experienced this state, pride in its (illusory) oneness. Narcissistic elation is characteristic of an object relationship that is played out, in its negative version, as a state of splendid isolation, and, in its positive version, as a desperate quest for fusion with the other, for a mirror-image relationship (i.e., a relationship with an idealized other). It involves a return to paradise lost and all that is attached to this idea: fusion, self-love, megalomania, omnipotence, immortality, and invulnerability. Narcissistic elation may subsequently be reactivated within a therapeutic context. Edmund Bergler wrote of ‘the narcissistic elation that comes from self-understanding’ (i.e., as through psychoanalysis); while Herbert Rosenfeld described what he called the re-emergence of “narcissistic omnipotent object relations”...in the clinical situation’.
2. My treating psychiatrist had practiced psychiatry in Vienna, Austria for twenty years. Beethoven’s funeral was held in Vienna in March 1827.

3. Earlier in the day I had an appointment with the nurse practitioner who prescribes my psychiatric medications. At the consult she said to me, “You have no friends.” At Beethoven’s funeral, the composer’s friend Franz Grillparzer gave a funeral oration which contains an observation that I have long identified with: “He fled the world because he did not find, in the whole compass of his loving nature, a weapon with which to resist it. He withdrew from his fellow men after he had given them everything and had received nothing in return. He remained alone because he found no second self (i.e., a “mirror-image object” The quest for such an object is an aspect of narcissistic elation).” It is estimated that from 20,000 to 30,000 people attended Beethoven’s memorial service. Beethoven had achieved fame.

My book *Significant Moments* quotes Grillparzer’s funeral oration:

I have one want which I have never yet been able to satisfy; and the absence of the object of which I now feel as a most severe evil. I have no friend, . . .

Mary Shelley, *Frankenstein.*

. . . he wrote to his sister in Basel:


. . . when I am glowing with the enthusiasm of success, there will be none to participate in my joy; if I am assailed by disappointment, no one will endeavour to sustain me in dejection. I shall commit my thoughts to paper, it is true; but that is a poor medium for the communication of feeling. I desire the company of a man who could sympathise with me; whose eyes would reply to mine. You may deem me romantic, my dear sister, but I bitterly feel the want of a friend. I have no one near me, gentle yet courageous, possessed of a cultivated as well as of a capacious mind, whose tastes are like my own, to approve or amend my plans. How would such a friend repair the faults of your poor brother!

Mary Shelley, *Frankenstein.*

Nietzsche’s loneliness was caused by his inner plight, for only the very few were receptive to what he said, and perhaps he wasn’t aware of even these few. Thus, he would rather be alone than together with people who did not understand him.

Alice Miller, *The Untouched Key.*

He remained alone, because he found no second self.

Barry Cooper, *Beethoven quoting Grillparzer’s Funeral Oration.*

In his solitude, he had new ideas and made new discoveries; since they were based on his most personal experiences, but at the same time concealed them, they were
difficult to share with others, and they only deepened his loneliness and the gulf between him and those around him.

Alice Miller, The Untouched Key.

4. On December 10, 2013, I posted the following quote from President Obama’s speech at the memorial service in South Africa for Nelson Mandela. The memorial service was held in a sports stadium; thousands attended:

Mandela showed us the power of action; of taking risks on behalf of our ideals. Perhaps Madiba was right that he inherited, “a proud rebelliousness, a stubborn sense of fairness” from his father. Certainly he shared with millions of black and colored South Africans the anger born of, “a thousand slights, a thousand indignities, a thousand unremembered moments…a desire to fight the system that imprisoned my people.”

The quotation highlights Mandela’s stubbornness and rebelliousness.

5. On December 12, 2013 I learn that the sign language interpreter assigned to interpret the public speakers at Nelson Mandela’s memorial service was a fake. He was an alleged schizophrenic whose signing, according to those knowledgeable about signing, was gibberish. Beethoven was deaf.

6. In the evening I posted a biographical video about Beethoven on this blog. The video is titled, “The Rebel,” and talks about Beethoven’s social isolation, his rebelliousness, his desire for fame, and his stubbornness. That evening I also did some research on the Internet and discovered that according to the Meyers-Briggs classification system, Beethoven would be classified as INTJ. This created a sense of identification since I have taken the Meyers-Briggs test and also scored INTJ. I may have registered the notion that Beethoven and I were mirror-image objects.

THE DREAM OF THE FOUR MILTONS

After retiring on the evening of Friday March 16, 1990 I had a dream about my then treating psychiatrist, Stanley R. Palombo, M.D. that I later designated “The Dream of the Four Miltons.” I had had a therapy session with Dr. Palombo earlier that afternoon.

The dream was in two parts. A significant image in the first part of the dream was a swimming pool. A significant image in the second part was a birthday cake.
I have just completed a session with Dr. Palombo. I go outside the apartment building in which Dr. Palombo’s office is located. Dr. Palombo is lounging in a swimming pool on an inflatable raft with a friend, also a physician. Dr. Palombo’s friend says to me: “Dr. Palombo is such a humble person, he probably never told you about his background, did he? Dr. Palombo is an outstanding physician. He was founder of the department of psychiatry at the School of Medicine at Penn State.” Dr. Palombo’s friend mentions that Dr. Palombo is Jewish. At that point I think, “I knew it. I knew that he was Jewish. He’s too fine a doctor not to be a Jewish doctor.” But then I think, “But ‘Palombo’ isn’t a Jewish name.” First I reason that perhaps Dr. Palombo is an Italian Jew. (Compare the chemist and writer Primo Levi, an Italian-Jewish Holocaust survivor. Also, for part of the year during the seventh grade, in the spring of 1966, I had an English teacher of Italian-Jewish heritage, Joanne Altus; I vaguely recall that her father was a pharmacist.) I then reject the idea that Dr. Palombo is Italian at all, and settle on the idea that he must be a Jew who has changed his name. I think, “His name must have been something like ‘Palombofsky’ and he changed it to ‘Palombo.’”

I find myself in a bedroom. I imagine that it is a hotel room. The room resembles my parents’ bedroom. I feel that I am an observer in the bedroom—that I have no active connection with the locale or the persons in the room. A woman in the room receives a telephone call. It is room service. The woman is advised that the hotel is sending a birthday cake up to the room, since it is the woman’s birthday. Dr. Palombo arrives. The woman tells Dr. Palombo that room service is sending up a birthday cake in honor of the woman’s birthday. Dr. Palombo becomes enraged. He says to the woman, “I am the great Stanley Palombo, a professor of medicine, and one of the greatest psychiatrists in the world. And room service is sending you a birthday cake? Who are you? You’re nobody!”

In the interpretation of dreams we look for overdetermination. Freud wrote in The Interpretation of Dreams that many features of dreams were usually “overdetermined,” in that they were caused by multiple factors in the life of the dreamer, from the “residue of the day” (superficial memories of recent life) to deeply repressed traumas and unconscious wishes, these being “potent thoughts”. Freud favored interpretations which accounted for such features not only once, but many times, in the context of various levels and complexes of the dreamer’s psyche. Overdetermination works in two directions: a single unconscious theme can give rise to various expressions in the manifest dream, or a single dream image can be the product of several unconscious themes.
Is it possible that at some level the seemingly unrelated images of swimming pool and birthday cake are related, the product of a single unconscious theme?

What if the two images both relate to the theme of birth? Perhaps the swimming pool reflects the amniotic fluid, while the birthday cake is a direct expression of the theme of birth. (The dream occurred on the evening of March 16, 1990, my niece’s 15th birthday.)

You may ask — so what? So we are dealing with the theme of birth, — what then? What is interesting is that my associations to the dream concern the founding of utopias: the founding of the State of Israel (a utopia conceived by the early Zionists); the city of Hershey, Pennsylvania (a model town founded by the candy manufacturer, Milton Hershey); and Pullman, Illinois (another model town founded by the railroad car manufacturer, George Pullman).

I direct your attention to the work of the psychoanalyst, Wilfred Bion. Bion argues that in every group, two groups are actually present: the work group, and the basic assumption group. The work group is that aspect of group functioning which has to do with the primary task of the group—what the group has formed to accomplish; will ‘keep the group anchored to a sophisticated and rational level of behavior.” The basic assumption group describes the tacit underlying assumptions on which the behavior of the group is based. Bion specifically identified three basic assumptions: dependency, fight-flight, and pairing. In pairing, the group has met for the purpose of reproduction—the basic assumption that two people can be met together for only one purpose, and that a sexual one’. Two people, regardless the sex of either, carry out the work of the group through their continued interaction. The remaining group members listen eagerly and attentively with a sense of relief and hopeful anticipation. The hoped for product of sexual union between the pair is a Messiah or a Utopia.

Is it possible that “The Dream of the Four Miltons” relates to my wish to unite sexually with my psychiatrist, Dr. Palombo, in the hopes of procreation: the birth of a Utopia? It appears that my unconscious concern for a utopia (think of Milton’s Paradise Lost) had caused me to construct a collection of associations around four persons named Milton who had personal significance for me.

We can see a possible relationship between the pairing fantasy embodied in Bion’s theory, on the one hand, and the unconscious “secret sharer” fantasy.
The psychoanalyst B.C. Mayer has described the relationship between two creative people in which one influences the other; they write for each other and share an unconscious fantasy of creating together in a sublimated sexual act.

“The secret sharer fantasy is a narcissistic one in which the double often represents the mother of early infancy with whom one merges and creates. It is also Oedipal in that in fantasy the relationship spawns a product — unconsciously a baby. The Oedipal attachment might be of the negative or positive type.”

THERAPY SUMMARY: NOVEMBER 27, 2017

A. DENIAL OF AGGRESSION

The therapist offered the observation, “Your brother-in-law took your sister away.” In fact, my sister and future brother-in-law began dating when I was 11 years old. They got married when I was 15.

This is a variation on the therapist’s simplistic depiction of attachment theory which sees relationships in terms of the formula, “Mother is good and desirable. When mother is absent the child is distressed.”

In this case, the therapist is saying, “Your sister was good and desirable. When your sister got married, you were distressed.”

But what about all the other important psychological and relational issues associated with my sister’s relationship with her husband? The complex psychological and relational issues got lost in the therapist’s projection: her view that the only pertinent
issue in relationships is that the individual needs an attachment figure, and that the absence of an attachment figure leads to distress.

a. What about the abusive aspects of my brother-in-law, specifically the fact that the relationship between my sister, brother-in-law and me constituted triangulation? Murray Bowen recognized that all two-party relationships have an element of instability, and that they tend to draw in a third party to moderate the anxieties of the two-party relationship. How did my sister and brother-in-law use me exploitively to moderate anxieties in their own relationship? What distress did this triangulation arouse in me?

Triangulation is a complex phenomenon usually centering on a narcissistically-disturbed party who triangulates a third party in his ongoing two-party relationship. Some narcissists have a tendency to view or judge themselves in terms of how they see themselves in competition with others. This competitive or “win-lose” attitude occasionally turns malevolent and will lead the person who suffers from the personality disorder (brother-in-law) to seek ways to sabotage, manipulate or otherwise undermine the position of others whom they see as a potential threat. One of the ways to do that is to devalue or bully people who are seen as a threat. When successful, the personality disordered individual gets a feeling of superiority or gratification from lowering the social status of a rival by attacking him or having others (such as sister) attack him. This also has the effect of making the rival (myself) more vulnerable to a more direct attack from the perpetrator (brother-in-law).

Victims of triangulation respond with fears of what other people might think of him. They may feel humiliated, concerned and self-protective. They might feel the urge to “clear their name” or “set the record straight”. Triangulation is fundamentally a form of emotional abuse that results in all the recognized consequences of emotional abuse. If triangulation experiences such as constant criticism, contempt, disapproval, rejection, put downs, and being ignored get internalized as global and negative beliefs about oneself, their negative impact will be enduring in adulthood. The experience of emotional maltreatment as through triangulation can become a traumatic event that impairs the individual’s sense of integration and unconscious interpersonal schemas. Farazmand, S. “Mediating Role of Maladaptive Schemas between Childhood Emotional Maltreatment and Psychological Distress among College Students.”

Keep in mind that I was a triangulated party in multiple triangles in my family. I was a triangulated party in (1) the relationship between my sister and (narcissistic) brother-in-law; (2) in the contentious relationship between my mother and father; and (3) in
the relationship between my mother and her (narcissistic) older sister (my aunt). The psychological stresses of my position in the family were intense. The family theorists Volgy and Everett state: “It appears that the unique level of emotional intensity in the borderline family requires multiple central triangles to balance and stabilize the system.” Chronic Disorders and the Family, Walsh, F. and Anderson, C.M., eds. (emphasis added). The therapist’s attempt to shoehorn my psychological difficulties into the simplistic formulation, “Your mother/sister was good and desirable, and when your mother/sister was absent you felt distress” is remarkably simplistic and distorted. And, of course, emotional abuse can contribute to narcissistic pathology in the victim. See below Section B, below.

b. The therapist ignored the significant relational issue concerning how my sister’s marriage (her moving away from home) affected the dynamics of the relationship between me and my parents. How did the marriage change the family dynamics? What happens in a family where one child is scapegoated and the omnipotent child leaves? How do the parents relate to the remaining scapegoat child?

c. The therapist ignored the important attachment theory issue of how my parents’ failure to protect me from the emotional abuse of my brother-in-law affected my internal working model. Attachment theorists emphasize the importance of attachment figures (primarily the parents) in responding to a child’s needs for protection from danger and for comfort when the child is feeling distressed by third-parties. The child also depends on the response that the expression of these needs elicits in the child’s caregivers. See Purnell, C. “Childhood trauma and adult attachment” (discussing childhood trauma and the development of a dismissive avoidant attachment style in adulthood). How did my parents’ failure to protect me affect my sense of agency or promote my pathological need for self-sufficiency?

d. The therapist failed to inquire into my own aggressive feelings toward my sister as a rival for my parents’ love. How was my response to my sister’s marriage — her leaving him — mediated by my pre-existing sibling rivalry with my sister? What about the gratification I experienced when my sister left the parental home; did I not thereafter enjoy the exclusive attention of my parents? What about the anger I had toward my sister for colluding in my brother-in-law’s triangulation of me since age 11?

e. Note that the therapist is applying an oedipal model to the three-way relationship sister/brother-in-law/me in the guise of attachment theory. In emphasizing the fact that my brother-in-law denied my emotional access to my sister, she has reduced my brother-in-law to his role as my sister’s husband — a mere interloper denuded of aggression — the way analytic theory reduces the Oedipal father to his role designation
(father/husband) while being totally oblivious to the actual relationship between the son and father. Doesn’t the therapist’s use of an Oedipal model to describe the relational issues between my sister, my brother-in-law and me not suggest that the therapist might be struggling with warded off (unconscious) Oedipal issues — (a desire for incestuous relations with her own father)?

The therapist employed a telling projection or displacement at the session on September 11, 2017:

THERAPIST: Your aunt wanted you to take your mother to Miami. Where was your father in all of this? Your aunt seems to treat your father as if he didn’t exist. What was the relationship like between your aunt and your father? “Your aunt seems to treat your father as if he didn’t exist.”

Isn’t the therapist describing herself and her therapeutic approach toward me? She treats my father as if he had no psychological significance. The therapist’s entire therapeutic approach is grounded in an interpretation (or misinterpretation) of attachments that treats the father as if he didn’t exist.

This raises an intriguing question: Is the therapist unconsciously masking her own oedipal conflicts — that is, her desire for incestuous relations with her father — with “relational theory?” That is, is the therapist’s interest in relational work a defense against her possible oedipal conflicts?

Keep in mind once again that the therapist majored in gender and women’s studies in college and wrote a master’s thesis on child sex predators — a topic that emphasizes the role of men as sexual predators. Does the topic of that master’s thesis represent an attempt by the therapist to work through her own warded off desire for sexual relations with a sexually potent father? See Chodorow, N. “Mothering, Object-Relations, and the Female Oedipal Configuration.” See also, Stiver, I.P. “Beyond the Oedipus Complex: Mothers and Daughters.”

I have some tentative thoughts about how the therapist’s therapeutic approach to her patients masks her warded off oedipal conflicts. The therapist’s dominant personality trait is agreeableness. It’s as if there were a total absence of anything aggressive in her interactions with me — as if she were a mother cradling an infant and cooing to the infant. She creates an “atmosphere of benign friendliness.” The Kleinian analyst Betty Joseph wrote about a patient who was obsessively agreeable. “[A]s the treatment goes on it is increasingly apparent that the agreeableness is a kind of drug that the patient
uses to placate and sedate her object and to protect herself from violent intrusion by the object. She sedates her own mind and so does not have to take seriously her own [Oedipal] fears, anxieties or deep concern about going ‘up the wall’, about madness — essentially linked with her ideas about her self, her mind [or body] being taken over [or sexually seduced] by her object [her father].”  Joseph, B. “Agreeableness as Obstacle.”  Does the therapist’s use an insistent and defensive agreeableness as a “drug” on her patients to placate and sedate them and thereby provide therapeutic relief to them — all the while unconsciously working through her own unconscious desire to be violently penetrated by her father (the way child sex molesters violently penetrate their victims)?  Again, why did the therapist use an oedipal model to deny my brother-in-law’s psychological aggression against me?  Why did the therapist need to depict my narcissistically-disturbed and interpersonally exploitive brother-in-law as an oedipal father who benignly denied my emotional access to my sister, thereby reducing him to his role designation, depicting him as a mere interloper without drives or identity?

B. THE IMPUTATION OF FEAR

During the session, the therapist said, “I see your core issue to be your intense fear of relationships.”

I have two problems with the statement. First, the statement seems to focus exclusively on my attachment insecurity, obscuring the importance of my psychic reality (the inner world) and the operation of a defensive structure that mediates that psychic reality. I have an inner world of unconscious wishes, conflicts and prohibitions: as well as impulses, drive derivatives and structures consequent to object loss (including possible unconscious guilt and pathological mourning) and environmental failure. This inner world is mediated by defenses that result in a particular social adjustment or maladjustment. Relational therapy, that is, therapy that focuses exclusively on social relations or attachments, fails to address my need in therapy to examine the subtle and elaborate camouflage that obscures the hidden structure and processes of my personality that result in a particular social adjustment. I am concerned about the therapist’s insistent need to examine the interpersonal world of social relations at the expense of examining my inner world of psychic representations that is mediated by defenses.

I have a pathologically introjective personality that promotes a high level of psychological distress relating to issues of autonomy and feelings of failure and guilt centered on self-worth: distress that is not related to social relations. I struggle with issues of identity, self-definition, self-worth, and self-control; again, issues that are not
related to current social relationships. In the pathologically-introjective, development of satisfying interpersonal relationships is neglected as these individuals are inordinately preoccupied with establishing an acceptable identity, and not specifically or directly because of attachment insecurity. Sidney Blatt wrote: “The focus . . . is not on sharing affection—of loving and being loved—but rather on defining the self as an entity separate from and different than another, with a sense of autonomy and control of one’s mind and body, and with feelings of self-worth and integrity . . . The basic wish is to be acknowledged, respected, and admired.”

My second problem with the therapist’s statement is that it is an overgeneralization that obscures the important etiologic role of abuse and scapegoating in my developmental environment in promoting the difficulties of social adjustment I experience. Psychological testing (MMPI) disclosed eight scales pertinent to social functioning that were elevated.

1. Avoidant disorder (MMPI T=78) rooted in an impinging or rejecting mother: People with a dismissive style of avoidant attachment tend to agree with these statements: “I am comfortable without close emotional relationships”, “It is important to me to feel independent and self-sufficient”, and “I prefer not to depend on others or have others depend on me.” People with this attachment style desire a high level of independence. The desire for independence often appears as an attempt to avoid attachment altogether. They view themselves as self-sufficient and invulnerable to feelings associated with being closely attached to others. They often deny needing close relationships. Some may even view close relationships as relatively unimportant. Not surprisingly, they seek less intimacy with attachments, whom they often view less positively than they view themselves. Investigators commonly note the defensive character of this attachment style. People with a dismissive–avoidant attachment style tend to suppress and hide their feelings, and they tend to deal with rejection by distancing themselves from the sources of rejection (e.g. their attachments).

a. Parenting style that promotes the dismissive avoidant personality:

There is some evidence that mothers of avoidant children are intrusive in addition to being rebuffing. One study reported that although mothers of avoidant infants left them alone when the infants were in a poor mood or a low interest state, the mothers initiated numerous play activities when their infants were already playing with high interest. These interferences usually resulted in cessation of the play activity and expression of uncertainty by the infant. Another study likewise found that these mothers were rejecting and impinging; the mothers tended not to hold their babies
when they were crying but might have grabbed their babies when they were engrossed with playing. Connors, M.E. “The Renunciation of Love: Dismissive Attachment and its Treatment.” Psychoanalytic Psychology, 14(4), 475-493 (1997).

The therapist’s attempt to link social avoidance to the child’s defensive reaction to mother’s absence (“Mother is good and desirable, and when mother is absent the child is distressed”) is distorted and simplistic and appears to serve the therapist’s own defensive needs (possibly including the therapist’s need to idealize her own mother).

b. Child abuse is etiologic for avoidant pathology:

Empirical findings suggest an environmental contribution to Avoidant Personality Disorder (AvPD). Researchers have highlighted early negative experiences with parents (e.g., maltreatment, separation) or peers (e.g., rejection) as a potential root of AvPD. For example, self-reported parental neglect has been associated with increased risk of AvPD in adult outpatients with depression. One study examined retrospective self-reports from treatment-seeking adults with personality disorder(s) (avoidant and borderline). The majority of participants indicated being the victim of some form of childhood abuse (73%; e.g., emotional, verbal, physical, sexual) or childhood neglect (82%). Moreover, another study found that secure attachment negatively, and disorganized/unresolved attachment positively, related to AvPD in a 14- to 18-year-old clinical sample, whereas avoidant and anxious/ambivalent attachments were not significantly related to AvPD. Although these findings could partly reflect evocative genetic characteristics of the child, they suggest that environmental factors also play a role.

Again, the therapist’s attempt to link social avoidance to the child’s defensive reaction to mother’s absence (“Mother is good and desirable, and when mother is absent the child is distressed”) is distorted and simplistic.

2.---Narcissistic pathology (MMPI T= 105)

I have a tendency to intense idealization as well as strong twinship needs possibly representing a defense against intense object need.

Kohut and Wolf argue that early deficits in mirroring, idealizing, and twinship (empathic failures by mother) lead to disorders of the self. Failure to have one’s selfobject needs met adequately may activate either mirror 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. Marmarosh, C.L. and Mann, S. “Patients’ Selfobject Needs in Psychodynamic Psychotherapy: How They Relate to Client Attachment, Symptoms, and the Therapy Alliance.” Psychoanalytic Psychology, 31(3): 297-313 (2014).

I show low social interest in persons who cannot satisfy my needs for twinship, idealization and mirroring.

Intense twinship needs can be a defense against the intense merger hunger associated with schizoid disorder. In the schizoid, fear of engulfment exists alongside profound merger hunger. All twin fantasies subserve multiple functions, particularly gratification and defense against the dangers of intense object need. In this formulation, the twinlike representation of the object provides the illusion of influence or control over the object by the pretense of being able to impersonate or transform oneself into the object and the object into the self. Intense object need, or merger hunger persists together with a partial narcissistic defense against full acknowledgment of the object by representing the sought-after object as combining aspects of self and other. In analysis, attention needs to be directed to the specific representation of the needed object in certain primitive transference paradigms instead of exclusive emphasis on the functions required of the object. Intense early needs of an object are best understood analytically within a conflict model in which they are modified by multiple wishes, drives, fears, dangers, and needs for defense. Coen, S.J. and Bradlow, P.A. “Twin transference as a compromise formation.” J. Am. Psychoanal. Assoc. 30(3):599-620 (1982).

a. Child abuse is etiologic for narcissistic pathology

Emotional deprivation interferes with the individual’s ability to experience intimacy, love, and acceptance; Emotional deprivation usually results from a lack of nurturance, empathy, or protection form parents. The underlying feelings are loneliness and emptiness and a sense that something is missing. Patients with emotional deprivation often hold exaggerated beliefs that they are not being cared for and understood, that they are not receiving sufficient attention, that others will not be there for them emotionally, and that people are unable or unwilling to meet their needs of emotional support. They often simultaneously yearn for close connection yet feel uncomfortable and back away if they begin to receive it. Young, J. and Flanagan, C. “Schema-Focused Therapy for Narcissistic Patients.”
Defectiveness involves a feeling of shame and humiliation because the patient believes that he or she is flawed or inferior and therefore unlovable to significant others; this usually results from severe criticism or rejection by parents in childhood. Note the connection to introjective pathology: severe introjective pathology may be rooted in a past in which important others controlling, overly-critical, punitive, judgmental, and intrusive—thus creating an environment in which independence and separation was made difficult. Young, J. and Flanagan, C. “Schema-Focused Therapy for Narcissistic Patients.”

3. Schizoid pathology (MMPI T= 85)

I experience intense fears of engulfment combined with a need for merger hunger (intense object need):

Schizoid pathology is characterized by a lack of interest in social relationships, a tendency towards a solitary or sheltered lifestyle, secretiveness, emotional coldness, detachment, apathy and a sense of meaninglessness. Affected individuals may be unable to form intimate attachments to others and simultaneously demonstrate a rich, elaborate, and exclusively internal fantasy world.

For schizoids, the process of separating with underlying connectedness and connecting while maintaining autonomy is foreign. Their lives are marked by the profoundly frightening and disturbing fact of separating without maintaining a sense of emotional connectedness and without a developed ability to connect again. They do not connect to others with much hope of being met and lovingly received. Schizoids do not believe they can be loved, and they fear that even if a relationship is established, the intimate connection means losing autonomy of self and other. Even feeling the need to connect would, in either case, be painful and/or frightening. It is dangerous to move into intimate connection if you cannot separate when needed.

Given what we know about the importance of flexible movement between connecting and separating for the growth and well-being of the individual, it is easy to understand how the typical childhood experiences of the schizoid leave him or her with deep-seated, often unconscious feelings of merger-hunger, on the one hand, and simultaneous fear of entrapment and suffocation on the other. These lead to universal twin fears that are fundamental to the schizoid process: the panic or terror of contact engulfment/entrapment and the panic or terror of isolation. These are particularly intense and compelling for the schizoid, who experiences them at the existential level of survival or death. Because the schizoid splits connecting and disconnecting, thus
losing easy movement between them, he or she is faced with the threat of becoming stuck at one pole or the other.

Of course, the danger of entrapment comes in large part from their own hunger for oneness and fear of abandonment, and the connection between their own merger-hunger and the fear of entrapment is mostly not in their conscious awareness. Many schizoid patients start treatment with the expectation that they will be devoured or abandoned in therapy. Although they may be conscious of this fear early in the process, the extent of the dual fears and the connection to their merger-hunger is usually not in awareness until much later. Until then the denial of both attachment and the need for intimacy predominates. Their own merger-hunger is projected onto others as a way of avoiding the awareness by attributing it to someone else. Sometimes these anticipations or perceptions are a projection, although they can also be accurate. The schizoid is impelled into relationship by need and driven out by fear. When faced with someone with whom they might be intimate, they find it both exciting and frightening. They are afraid that they will devour their lovers with their need or that the lover will be devouring, deserting, or intrusive. They might lose their individuality by overdependence and merger-hunger or lose the relationship by being too much, too toxic, or too needy. The solution to these dilemmas is Guntrip’s schizoid compromise—to remain half in and half out of the relationship, whether in the form of marriage without intimacy, serial monogamy, or two lovers at the same time. Needs and fears will often be either denied or acknowledged in an intellectualized manner. Frequently such individuals will oscillate between longing for the intimate other and rejecting him or her, or they may stay in a stable halfway position not able to commit to being fully in the relationship or discontinuing it.

For children who later become schizoid adults, one way of coping with a world that is too big, menacing, intrusive, unresponsive, and/or abandoning is to deny any need, weakness, and dependency and to promote the illusion of self-sufficiency. They learn to survive by living without feeling dependence, desire, need, or fear. The schizoid is especially trying to avoid burdening and killing parents with his or her needs. Schizoids avoid awareness of attachment in various ways. The most common is splitting off or disassociating from needs and feelings that are overwhelming. Conformity can also be a means of avoiding awareness of need and fear as can obsessive-compulsive self-mastery, addiction to duty, or service to others.

The schizoid experiences loneliness, futility, despair, and depression, although the latter is somewhat different from neurotic, guilt-based depression. Both are comprised of dysphoric affects and an avoidance of primary emotions and full awareness.
However, neurotic depression has been described as “love made angry.” That is, the 
depressed person feels angry at a loss followed by sadness and broods darkly against 
the “hateful denier.” This aggressive emotional energy then gets turned against the 
self. In contrast, schizoid despair has been described as “love made hungry.” The 
person experiences a painful craving along with fear that his or her own love is so 
destructive that his or her need will devour the other.

An important part of how the child copes with this situation is by splitting the self. 
Survival is achieved by relating to the world with a partial self or “false self,” one that is 
devoid of most significant affect and relates on the basis of conforming to others’ 
requirements rather than on the basis of organismic experience. Guntrip used the 
phrase “the living heart fled” to describe the situation in which the vital energies, 
emotions, and vitality affects are held inside, leaving an empty shell to interact with 
others and to direct human relations. This schizoid pattern creates external relations 
that are not marked by warm, live, pulsing feelings. Instead, when interpersonal 
nurturance is available, schizoid individuals fear a loss of self from being smothered, 
trapped, or devoured. When strong desire or need is aroused, they tend to break off 
the relationship.

The inner schizoid world is characterized by a constant fear of desertion and feelings of 
being unwanted and unlovable, all of which may remain out of awareness until they 
emerge well into the therapy. The fear of abandonment relates to the patient’s 
attitude toward his or her own intense hunger, and even if the hunger itself is not in 
awareness, it colors the schizoid patient’s adult functioning. The schizoid patient wants 
to ensure the therapist’s or lover’s presence, to “possess” the other.

a. Child abuse is etiologic for schizoid pathology

Poor parenting might have a strong, lasting, negative impact on the social-emotional, 
cognitive and moral development of the child. One study revealed in a sample of 593 
families that problematic parental behavior (harsh punishing, poor parental 
supervision, verbal abuse) in the home during the child-rearing years was associated 
with elevated risk for offspring personality disorders at mean ages of 22 and 33 years. 
Low parental affection or nurturing was associated with elevated risk for offspring. In a 
sample (793 mother and offspring from New York follow-up 18 years from age 5-22) of 
youths who experienced childhood verbal abuse had elevated schizoid symptom levels 
during adolescence and early adulthood after the covariates were accounted for. A 
child’s experience of physical, social and verbal abuse may provoke in the already 
vulnerable and shy child strong feelings of being unlovable, inferior, shameful (with
linked self-hate) and frustration. This might bring about attachment and associated social interactional problems which, in turn, could contribute to loneliness and schizoid etiology.

Emotional abuse/neglect might cause deep feelings of inner emptiness and a blurred and/or confused identity that can be observed in many patients with schizoid disorder. Emotional abuse/neglect is related to trauma, low self-esteem, self-hate, social withdrawal and maladjustment, social-emotional incapacities, avoidance coping, and neurobiological dysfunctions which might be all determinants of schizoid disorder. Martens, W.H.J. “Schizoid personality disorder linked to unbearable and inescapable loneliness.” Eur. J. Psychiat. 24(1): 38-45 (2010).

4. Characterological depression (MMPI T = 76)

My characterological depression is possibly related to social anhedonia (lack of pleasure in relationships)

a. Childhood emotional abuse is etiologic for characterological depression.

Both emotional abuse and emotional neglect were associated with later symptoms of anxiety and depression. Wright M., Crawford E., Del Castillo D. “Childhood emotional maltreatment and later psychological distress among college students: The mediating role of maladaptive schemas.” Child Abuse Negl. 33(1):59-68 (2009).

5. Social discomfort (MMPI T = 81), Shyness and Self-Consciousness (MMPI T = 68) (a T score above 65 is significant)

a. Childhood abuse is etiologic for social discomfort.

Both avoidant disorder and social phobia were associated with negative childhood experiences. Patients with avoidant disorder reported more severe childhood neglect, most pronounced for physical neglect, compared to patients with social phobia without avoidant disorder. The difference between the disorders in neglect remained significant after controlling for temperamental differences and concurrent physical, sexual, and emotional abuse. Both social phobia and avoidant disorder were associated with high levels of attachment anxiety and avoidance, and a large majority of patients in both groups had an insecure attachment style. Eikenæs, I. “Avoidant Personality Disorder and Social Phobia. Studies of Personality Pathology and Functioning, Childhood Experiences and Adult Attachment.” Ph.D. Thesis.
6. Social Alienation Schizophrenia (MMPI = 72):

Elevations on this scale are traceable to abuse and scapegoating in the family environment. Note that abuse and scapegoating can lead to feelings of alienation (a feeling of being different from other people). I experience intense feelings of alienation, a sense of being different from other people.

7. Social Alienation-Family Discord (MMPI T = 71):

Elevations in this scale are traceable to abuse and scapegoating in the family environment. Note that abuse and scapegoating can lead to feelings of alienation (a feeling of being different from other people). I experience intense feelings of alienation, a sense of being different from other people.

C. THE NEED FOR RELATIONSHIPS

At one point in the session, the therapist said to me, “Tell me about your relationships.”

a. I am concerned that the therapist has overlooked the most important relationship in the therapeutic context, namely, the relationship between the therapist and me. Why does the therapist show no interest in the transference relationship?

b. I am concerned that the therapist needs explicit reports about my relationships but lacks the analytic skills to interpret the relational aspects of issues I raise that are not explicitly relational.

At the beginning of the current therapy session I talked about attachment theory. I said that during the past two weeks I had been researching the work of John Bowlby and attachment theory. In my sessions I frequently offer intellectualized discussions about a variety of psychological topics.

It recently occurred to me that my intellectualizations and my letters to the therapist may relate to a relational issue, namely, transitional objects.

Winnicott introduced the concepts of “transitional objects” and “transitional experience” in reference to a particular developmental sequence. With “transition” Winnicott means an intermediate developmental phase between the psychic and external reality. In this “transitional space” we can find the “transitional object”. The transitional object is a bridge, or space, between the child’s inner world and the outer
world of objective reality. The transitional object is an outgrowth of the child’s emerging autonomy from mother: as symbiosis is superseded by the infant’s sense of omnipotence (“mother comes to me when I wish it”); superseded by the child’s painful sense that mother is a separate person who is not under his control, which tells the child that he has lost something; superseded by the transitional phase in which the child learns that through fantasy he can imagine the object of his wishes and find comfort. A transitional object (a blanket or teddy bear or such) can be used in this process.

In this regard is it not important to see the connection of transitional phenomena to my insistent feeling that I need a form of psychotherapy – psychodynamic (or analytic) therapy – in which my private world of unconscious fantasies, wishes, conflicts and prohibitions can be made public through the use of language? That is, for me the therapeutic narrative (which I summarize in my letters) is perhaps a transitional object. See Favero, M. and Ross, D.R. “Words and Transitional Phenomena in Psychotherapy.” Is it possible that ideas and intellectualized constructs as well as my letters are a transitional object that allow me to make my inner world intelligible to the world of objective reality?

When I was a small kid I had a set of wooden blocks. This was one of my favorite toys. I would spend a considerable amount of time working and reworking the arrangement of the blocks in novel structures that suited my fancy.

My letters to my therapist are arrangements and rearrangements of ideas. Many of the ideas I borrow from technical psychoanalytic sources. My letters and their composite ideas are like a castles I have built of wooden blocks. Each wooden block — arranged with other blocks to form a composite structure — is a mere instrument used in the service of the expression of an inner truth, a psychological truth, embodied in the castle I have created. It is well to keep in mind that with the transitional object the individual manages the relations between the outer objective world and the inner world of subjective experience. In my wooden castles I have used concepts of the outer world of knowledge (wooden blocks) to express an inner world of subjective experience (the castle).

People may say, “Does he even know what he’s talking about?” Does he even understand Kohut and Klein? My response is — does that matter? One should look for meaning in the “castle” I have built: why that arrangement of blocks satisfies me — why that overall structure satisfies me. One should see each letter as an aesthetic construction that lies beyond truth or persuasive power. One should look for the truth
of the letter in the subjective meaning of the castle as a whole — the way one would look at a painting, which is fundamentally a composite of colors and shapes.
Lerner and Ehrlich write: “The specific form of transitional phenomena will differ at each stage due to maturational and developmental shifts in cognitive functioning, libidinal focus, affect organization, and the demands of the environment. The level of cognitive maturity as well as other dimensions of personality become particularly important in determining and delimiting the manifest forms of transitional phenomena. As other functions including self- and object- representations become increasingly differentiated, transitional objects are thought to become increasingly less tangible and more abstract. For example, in contrast to the transitional objects of early childhood, the transitional phenomena of adolescence such as career aspirations, music, and literature are more abstract, ideational, depersonified, and less animistic. They are also increasingly coordinated with reality. Rather than the concrete fantasy representation, it is the ideas, the cause or the symbolic value that becomes important. Regardless of manifest content of the transitional object, transitional phenomena are thought to promote the internalization of core self-regulatory functions that include narcissistic regulation in terms of sustaining self-esteem, drive regulation, superego integration, ego functioning, and interpersonal relationships. Through the use of increasingly abstract transitional phenomena, the individual is better able to synthesize discrepant events in his or her life experience. Representational capacities evolve in concert with and become more complex because more alternative solutions and choices can be conserved simultaneously. With increased development, the function of transitional phenomena may also change form one of self-soothing to one of enrichment the quality of experience.”

Therapists say, “You need to talk about your feelings.” But will feelings in themselves mean anything to the therapist?

If I say to my therapist: “I fell on a curtain rod when I was 2 years old and it hurt.” That statement has no meaning for the therapist, even though I have expressed feeling. He thinks: “The patient fell on a curtain rod when he was two years old and it hurt.” So what?

But if I say, the literature says that early childhood physical trauma can affect superego development, i.e., impulse control — I have in effect translated my inner world and personal experience into something meaningful to the outer world. That is to say, concepts can be transitional objects in therapy — a way to translate idiosyncratic feelings into something meaningful for another person.
Perhaps in this sense the psychoanalytic literature serves as a transitional object that allows me to relate my inner world to the outer world of objective reality.

What if you view my “intellectualization” as a desperate need for transitional objects? What does that mean? What does it mean when a person has a desperate need for transitional objects? Doesn’t that say something about the relationship between my mother and me? Again, the therapist lacks the analytic skills — the tools — to view my intellectualizations as relational; she lacks the sophistication to see relational issues in the seemingly non-relational; she needs concrete evidence of “relationships.”

COUNTERTRANSFERENCE ISSUES:

Blatt developed a two-configuration model of personality. So-called anaclitic individuals are concerned primarily with libidinal themes, such as, obtaining and maintaining close and nurturing interpersonal relations, while so-called introjective individuals are mainly concerned with aggressive themes and securing a positive sense of self, i.e., they have a concern for autonomy and self-definition. Anaclitic concerns are primarily oral in nature, originating from unmet needs from an omnipotent caretaker (“the good and desirable mother”); while introjective concerns are related to the (more developmentally advanced) formation of the superego and involves the more developmentally advanced phenomena of guilt and loss of self-esteem during the oedipal stage.

I had previously thought of my therapist as primarily anaclitic and lacking in introjective development. I no longer believe that to be the case. My thinking about the therapist has evolved. I now tentatively believe that the therapist has high anaclitic development plus significant introjected development that is powerfully defended against.

It appears that the therapist is defending against aggressive issues in her personality in a variety of ways:

a. The therapist denied my brother-in-law’s aggression against me, depicting my brother-in-law as a symbolic and benign oedipal father who impeded my emotional access to my sister, rather than a narcissistically-disturbed person who aggressed on me. The therapist used an oedipal model in the guise of an attachment model that depicted my sister as the absent mother of infancy. In effect, the therapist used a disguised oedipal model to deny an aggressive theme.
b. The therapist failed to see the connection of my fear of social relations to childhood emotional abuse. Again, the therapist seems to deny my defensive response to environmental aggression in favor of a model that explains my social avoidance in terms of my infantile defensive response to mother’s absence. In attachment theory it is important to distinguish avoidance rooted in a defensive response to mother’s absence from a defensive response to aggression or trauma in the environment. The therapist does not appear to make that important distinction.

c. The therapist may be denying her own Oedipal conflicts, which can be seen in her therapeutic work which denies the psychological significance of the father; her college major (gender and women’s studies) and her master’s thesis (that concerned sexually predatory men); and her use of an Oedipal model in the guise of attachment theory.

d. The therapist may also be denying her anal sadism. Her simplistic and distorted interpretation of attachment theory reduces personality to a nursery model in which all persons are struggling with the need for the comforting nurturance of mother and which posits all distress as centering on maternal absence. She denies the complexity of personality: the inner world of multiple, distinct and irreducible psychic representations and the complex organization of defenses that mediate that inner world. The therapist seems bent on destroying individual differences and undoing organization.

Attachment theory, applied in a simplistic fashion, can serve the defensive needs of anal sadism in which the identity of the patient is denied (the infant does not have a distinct identity or personality, that is, a collection of unconscious wishes, conflicts, prohibitions, fantasies and defenses) and the patient’s personality is reduced to no more than a derivative of the biologic need for attachment. In a simplistic use of attachment theory — in which the patient is reduced to an infant whose only identity centers on attachment to mother — the complexities of the patient’s personality, or psychic reality, are subsumed in the role designation of infant just as in a lab experiment the individual rats are seen simply as fungible lab animals (or in the concentration camp, the inmates are seen simply as numbers). Whereas, a psychodynamic approach is dominated by attempts to penetrate the subtle and elaborate camouflage that obscures the hidden complex structure and processes of individual personality, or individual identity. The statement, “I see your core conflict centering on your intense fear of relationships” can be a defensive one, in effect saying to the patient, “You have no individual identity” (you are like a lab rat which is indistinguishable from all other lab rats) (you have no name or identity; you are just a
number – you are simply a creature in need of, or fearful of, attachments). I see your core issue is that you are intensely fearful of relationships.

The psychoanalyst Janine Chasseguet-Smirgel noted how the Marquis de Sade represented the anal sadistic urge to destroy differences and undo organization. His helter-skelter coupling of sister and brother, parent and child, etc. — was done not merely to satisfy forbidden incestual wishes. Rather, “incest is linked to the abolition of ‘children’ as a category and ‘parents’ as a category.” Sade wished to destroy the actual world of differences, of categories, of stations, and create an “anal universe where all differences are abolished.” Volney Patrick Gay, Freud on Sublimation: Reconsiderations (emphasis added).

Chasseguet-Smirgel saw anal sadism as driving the need to see individuals as indistinguishable from each other. In her essay “Perversion and Universal Law” Chasseguet-Smirgel referred to “an anal universe where all differences are abolished . . . All that is taboo, forbidden, or sacred is devoured by the digestive tract, an enormous grinding machine disintegrating the molecules of the mass thus obtained in order to reduce it to excrement.”