PSYCHOLOGICAL REFLECTIONS
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Thoughts about Psychotherapy

GARY FREEDMAN
INTRODUCTION

I have written summaries of several clinical sessions I have had with my psychotherapist, a social worker. My therapist believes that my letters distort her work and that I present a biased view of her. Well, that is true. But my approach is valid and justifiable. My summaries of my therapy sessions are, in my view, an elaboration of a personal experience and not an ideologically objective portrait of my therapist.

My summaries are not and cannot be unbiased. In spite of the inescapable bias that is introduced in the process of a patient summarizing a therapy session, he still feels he has certain ethical obligations regarding how he portrays the therapist. My summaries are based on un-staged, un-manipulated actions. The editing is highly manipulative and the writing is highly manipulative. What I choose to write about, the way I write it, the way I edit it and the way I structure it – all of those things represent subjective choices that I have to make.

I only summarized a few sessions – near nothing. The compression within a sequence of innumerable interactions represents choice and then the way the sequences are arranged in relationship to the other represents choice. All aspects of summarizing a course of therapy represent choice and is therefore manipulative.

But the ethical aspect of it is that you have to try to make a report that is true to the spirit of your sense of what was going on. My view is that these summaries are biased, prejudiced, condensed, compressed but fair. I think what I do is write summaries that are not accurate in any objective sense, but accurate in the sense that I think they’re a fair account of the experience I’ve had in doing therapy. I think I have an obligation to the therapist to summarize the sessions so that the letters fairly represent what I felt was going on at the time in the original sessions.
May 18, 2018  
3801 Connecticut Avenue, NW  
Apartment 136  
Washington, DC  20008  

Jerri Anglin, LICSW  
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The Wendt Center  
4201 Connecticut Avenue, NW  
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Dear Ms. Anglin:

At our therapy session on May 14, 2018 you asked me to think about whether I wanted to continue in treatment with you. I have given some thought to the issue and I want to share my ideas in writing about the matter. Also, reducing these ideas to a writing may be useful for consultation purposes in the event you choose to terminate my work and will need to locate another therapist for me. This letter will facilitate an orderly transfer of responsibility and allow you to discuss all pertinent information with the new service provider.

I believe there are substantial reasons for me to continue in treatment at the Wendt Center: reasons that center on issues of borderline disorder and trauma.

1—Diagnosis of Borderline Disorder (BPD)

I entered psychotherapy with Louis C. Alikakos, M.D. (deceased), a psychiatrist, in January 1977, at age 23. In November 1977, while still in treatment with Dr. Alikakos, I attempted suicide. It was a serious suicide attempt (Elavil overdose). Dr. Alikakos diagnosed me with BPD. While my current clinical presentation and psychological test results do not disclose BPD, I may nonetheless have an underlying borderline

2—Family Environment Conducive to the Development of Borderline Disorder

I grew up in the type of family that is recognized to foster 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.”

There was also pervasive triangulation in my family with two family members drawing in a third member to preserve emotional balance between the original dyad. Triangulation is a recognized feature of borderline families. There were numerous such triangles in my family.

3—Emotional Invalidation as Etiologic for Borderline Disorder

Growing up in an environment perceived as invalidating is one factor commonly discussed as contributing to the development of BPD. To invalidate means to attack or question the foundation or the reality of a person’s feelings. In essence, invalidation is telling another person that his feelings are “wrong.” An environment perceived as invalidating
generally means that the child grows up feeling that his emotional responses are not correct or considered in the regular course of things. Over time, this can result in confusion and a general distrust of the person’s own emotions.

There is every reason to believe that invalidation was a chronic and pervasive feature of my early family environment. Perhaps we may refer to chronic invalidation of a child’s feelings in a borderline family as a “traumatic stressor,” with severe psychological consequences for the individual.

We have talked about my extravagant need for mirroring and validation in my therapy relationships. It’s as if I am constantly seeking out validation from therapists and experience my perception of invalidation as profoundly threatening.

We see my need to write profusely about my sessions with my past therapist, suggesting that I struggle desperately to preserve my psychological integrity against therapeutic interpretations that I experience as traumatic and threatening. At my session with you on May 14, 2018 I talked about the self-soothing I derive from letter writing – as if letter writing for me was a verbally sophisticated and intellectualized form of cutting or drug addiction: a way to ward off psychological pain and restore a sense of emotional balance. It's ironic that many therapists treat cutting by recommending that the client write about his feelings of distress. See, e.g., Dombeck, M. “Self-Soothing Techniques: Venting and Journaling.” And yet my writing only seems to arouse in therapists a reaction of scorn and enmity, as if the therapist were saying, “You may write, writing is therapeutic, but just don't write too well, too perceptively, too critically, too analytically, and with too much insight. Restrain yourself!”

At my last session with you, on May 14, 2018 I experienced several of your comments as invalidating and stressful. I expressed curiosity – a valid emotional reaction – about why you failed to address a list of
symptoms I submitted to you in an email I sent before our first session; I expressed curiosity – a valid emotional reaction – about why you did not talk about the “specifically traumatic” aspects of several of my early experiences; and when I presented my re-interpretation of a psychological test report that reflected my emotional turmoil about the original report you seemed to dismiss my perfectly valid feelings. You interrogated me about why I re-interpreted the test scores. You asked me, “Are you always right?” (Note significantly that the question you posed is an “all or nothing” statement, a type of statement that is recognized by CBT practitioners as a cognitive distortion). In fact, I never said you were wrong about anything. I never said I was right about anything. I was simply reacting to feelings of curiosity and my feelings of emotional turmoil about having paid $400 (not reimbursed by insurance) for a psychological test report that had little value. Once again, my act of re-interpreting the test scores can be viewed as “a verbally sophisticated and intellectualized form of cutting or drug addiction: a way to ward off psychological pain and restore a sense of emotional balance.” Once more, it’s as if I am being told, “You may use your intellect to self-sooth, just don't be too clever about it!”

I am reminded of the psychoanalyst Alice Miller’s observations about the behaviors of many parents of gifted children who feel threatened by the gifted child’s intense feelings: “Often a child’s very gifts (his great intensity of feeling, depth of experience, curiosity, intelligence, quickness—and his ability to be critical) will confront his parents with conflicts that they have long sought to keep at bay by means of rules and regulations.” Miller, A. *The Drama of the Gifted Child: The Search for the True Self.*

I propose that my extravagant need for validation in therapy may in fact be a trauma symptom – an adaptation to a pervasively invalidating family environment – that can be addressed by a trauma-centered approach: the very approach offered by the Wendt Center. I propose that we can work with my extravagant need for validation in therapy if we place that need for validation in a trauma context.
4. Borderline Disorder – Intuitive Giftedness

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 (including thoughts about the therapist).

The authors state that the client with intuitive giftedness has an “absolute right” to share his perceptions of others – including therapists, including the client’s intuitive perceptions of the therapist's intrapsychic life.

My observations about you and past therapists – such as those I recorded in my letters to my last therapist – can be seen as growing out of a non-pathological gift that accompanies BPD and needs to be recognized as a
fundamental part of my social functioning and interpersonal relatedness – including my relationships with therapists.

How does a therapist work with a client who is intuitively gifted and has a legitimate right to express that gift in therapy? In my last therapy, when I offered psychological observations about the therapist, the therapist replied on one occasion, “You are shifting the focus.” The psychiatric literature I cite validates the client’s right to express such psychological observations rooted in the client’s giftedness. Recognizing the gifted client’s right to express his intuitive giftedness is both therapeutic and an appropriate form of validation for the client.

5. Trauma and the Repetition Compulsion

Repetition compulsion is a psychological phenomenon in which a person repeats a traumatic event or its circumstances over and over again. This includes reenacting the event or putting oneself in situations where the event is likely to happen again. This "re-living" can also take the form of dreams in which memories and feelings of what happened are repeated, and even hallucination.

The term can also be used to cover the repetition of behavior or life patterns more broadly: repetition compulsion describes the pattern whereby people endlessly repeat patterns of behavior which were difficult or distressing in earlier life.


At my last session I talked about how I felt in my life as if I was continually rolling a boulder up a mountain only to see the boulder roll back to the ground – repeating the sequence again and again.
We can examine that scenario as a trauma symptom: as my need to re-experience and master an earlier trauma that involves the issue of masochism that lies beyond my volitional control. I have a good example of that. At my last job I was an outstanding employee. One of my job evaluations – written months before I was terminated – said “Gary seems as close to the perfect employee it is possible to find.” Another evaluation said, “Gary is a team player.” Yet another said, “Gary inspires his coworkers.” A few months later the employer suddenly terminated me after I complained about a racist supervisor – thereafter the employer alleged that I suffered from severe mental illness and that I was potentially violent. The supervisor in question told employees that I was a homicidal maniac!

Something else that is psychologically intriguing. There is evidence that I have a sense of entitlement that is rooted in the implicit belief that I have a right to recompense for childhood maltreatment. We can see my living on the disability dole for the past 27 years as evidence of that sense of entitlement. But this is striking: I qualified for disability on the basis of defamatory statements made by my past employer that misrepresented my employment history and mental health. In fact, I worked hard and did everything in my volitional control to continue working and even get a job promotion. Did a passive repetition compulsion bring about my job termination – despite all my best efforts – and create the circumstances that allowed me to gratify an unconscious sense of entitlement? I did not consciously create the circumstances that allowed me to gratify my unconscious sense of entitlement. All of my volitional behaviors were directed at opposite goals: success on the job and promotion. And throughout my employment I was in fact recognized as an exemplary employee.

Again and again in my life I seem to experience bad things despite my best efforts to create a good outcome. Again and again, I do things that are absolutely appropriate like using writing as a form of self-soothing or offering my thoughtful and deeply considered reflections about a
psychological test report – only to arouse the negative reaction of others. It's as if I induce others to play a role in my internal drama, reinforcing an unseen private tormenter. It's as if I unconsciously arrange for external situations that represent internal anxieties – despite volitional behaviors that are intended to bring about an opposite outcome.

The psychoanalyst Melanie Klein offers some suggestions about the psychodynamics that can give rise to a symbolic repetition of childhood events in adulthood despite the individual’s best efforts to have a successful outcome.

Discussing Klein’s work Greenberg and Mitchell write: "Early internal objects of a harsh and phantastic nature are constantly being projected onto the outside world. Perceptions of real objects in the external world blend with the projected images. In subsequent reinternalization the resulting internal objects are partially transformed by the perceptions of real objects. Klein suggests that the early establishment of harsh superego figures actually stimulates object relations in the real world, as the child seeks out allies and sources of reassurance which in turn transform his internal objects. This process is also the basis for the repetition compulsion, which involves a constant attempt to establish external danger situations to represent internal anxieties. To the extent to which one can perceive discrepancies between internally derived anticipations and reality, to allow something new to happen, the internal world is transformed accordingly, and the cycle of projection and introjection has a positive, progressive direction. To the extent to which one finds confirmation in reality for internally derived anticipations, or is able to induce others to play the anticipated roles, the bad internal objects are reinforced, and the cycle has a negative, regressive direction." Object Relations in Psychoanalytic Theory at 132 (Cambridge: Harvard University Press, 1983).

I seem to induce others into playing a role scripted by an unconscious playwright who is determined to see repeat performances of a perverse drama originating in my childhood. Klein’s psychoanalytical
observation’s find confirmation in the psychiatric literature about BPD. Park and Imboden at Johns Hopkins state that borderlines manipulatively induce feelings in others like those the patients themselves experience, that is, projective identification (citing Kernberg). “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.”

Park and Imboden implicitly place the repetition compulsion – i.e., inducing others to perform the patient’s internal script in the client’s effort to re-enact and master trauma – in the context of BPD and the symptom of projective identification.


Arnold Modell, M.D. reported a case of a patient who was narcissistically inaccessible in treatment. The patient was intellectually gifted. When Dr. Modell offered an interpretation the patient often disputed the doctor or rejected his professional opinion. In due course, Dr. Modell worked out the following reconstruction of the patient’s childhood. The patient had been an intellectually precocious child whose mother had incompetent parenting skills. As a young child the patient made the implicit determination that if he adopted his mother’s view of the world, he would be lost. He adapted to an incompetent mother by developing a pathological self-sufficiency, trusting only his own perceptions and intuitions. As an adult in psychotherapy, the patient brought with him into the clinical setting the childhood adaptation of having been a gifted child struggling to survive in the face of an incompetent mother. Modell, A., “Narcissistic Defense Against Affects and the Illusion of Self-Sufficiency.”

It is my opinion that it is good for a therapist to refrain from simplistically designating aspects of the resistance or transference – i.e., aspects of the patient’s relationship with the therapist – as simply “bad
behaviors,” “perversity,” or a need to always be right. Rather, these “objectionable” behaviors should be seen for what they really are – aspects of the disorder. In my opinion it is questionable whether it is a good idea for a therapist to say to a patient, in effect, “I am frustrated by your resistance, I am offended by your transference: you need to modify your resistance and your transference to suit my needs.”

I am attracted to the idea of therapy as a kind of a Rorschach test in which there are no good responses and no objectionable responses (“I am highly offended that you think that looks like a horse! You need to say it looks like an antelope.”). Every response is simply analyzable. Every response is simply a meaningful expression of the patient’s inner world. We can look at that meaning.

**Conclusion**

I believe there are substantial reasons to continue at the Wendt Center. I have described significant areas in which my psychological functioning seems to be intimately connected to trauma symptoms (and possible underlying borderline organization) and that I can benefit from an informed trauma-centered approach. These areas are (1) traumatic response to a disturbed family environment; (2) traumatic response to invalidation in the family environment; (3) the mediation of intuitive giftedness; and (4) issues of repetition (including repetition of feelings) and revictimization.

Again, I am not saying you are wrong about anything. I am simply saying these are my opinions and that these opinions grow out of underlying distressed feelings and intuitive perceptions I have about my life situation, my difficulties in therapy, and my psychological needs and character pathology. In therapy we can examine those feelings in the context of an informed trauma-centered approach.
Perhaps the Wendt Center psychiatrist could offer input about this matter.

Sincerely,

Gary Freedman
Additional Thoughts: How Does A Creative Personality Do Psychotherapy?

I was recently thinking about something tangentially related to my problems with therapists. I get the idea from many of them that they think: “He reads some Freud and now he wants to apply Freud’s ideas to himself. He needs to disabuse himself of these psychoanalytical ideas he reads and immerse himself in the work of therapy.”

That’s simplistic. I did not develop an interest in Freud when I was a teenager the way a teenage girl might suddenly obsess on the joys of baseball because her new-found boyfriend happens to be the star pitcher on the high school baseball team.

I’ve worked out something in my mind. Freud developed psychoanalysis on his own. He did not adopt somebody else’s ideas or psychological orientation to the world. His work and theories grew out of his personality and his psychological predilections. When Freud was a teenager, he was just a teenage kid with his own personality and psychological disposition. In fact, I read that at one point Freud thought about becoming a lawyer like his ten year older brother, Alexander. If he had become a lawyer, he would have had the same personality. It would have been Sigmund Freud attorney instead of Sigmund Freud medical doctor. But it would be the same Freud. The same person. The same personality.

What I see is that Freud probably had certain personality traits that disposed him to a particular orientation to the world. I speculate that if another person has traits similar to Freud’s he just might be drawn to psychoanalytic thinking. It’s these core psychological traits that are important. It’s the psychological traits that need to be considered as important determinants in my interest in psychoanalysis, not simple hero worship. It may be these core psychological traits that determine my orientation to therapy and the way I relate to therapists.
What are the traits that disposed Freud to psychoanalytic thinking. Do I have similar traits?

The teenage Freud may have had a high need for cognition. The need for cognition (NFC), in psychology, is a personality variable reflecting the extent to which individuals are inclined towards effortful cognitive activities. Need for cognition has been variously defined as “a need to structure relevant situations in meaningful, integrated ways” and “a need to understand and make reasonable the experiential world”. Higher NFC is associated with increased appreciation of debate, idea evaluation, and problem solving. Those with a high need for cognition may be inclined towards high elaboration. Those with a lower need for cognition may display opposite tendencies, and may process information more heuristically, often through low elaboration.

The teenage Freud may have had a high level of psychological mindedness. Psychological mindedness refers to a person’s capacity for self-examination, self-reflection, introspection and personal insight. It includes an ability to recognize meanings that underlie overt words and actions, to appreciate emotional nuance and complexity, to recognize the links between past and present, and insight into one’s own and others’ motives and intentions. Psychologically minded people have above average insight into mental life.

The teenage Freud may have had a high level of “openness to experience.” Openness to experience involves six facets, or dimensions, including active imagination (fantasy), aesthetic sensitivity, attentiveness to inner feelings, preference for variety, and intellectual curiosity. People high in openness are motivated to seek new experiences and to engage in self-examination. Structurally, they have a fluid style of consciousness that allows them to make novel associations between remotely connected ideas. Openness has been linked to both artistic and scientific creativity as professional artists and scientists have been found to score higher in openness compared to members of the general population. People high in openness may be more motivated to
engage in intellectual pursuits that increase their knowledge. Openness to experience, especially the Ideas facet, is related to need for cognition, a motivational tendency to think about ideas, scrutinize information, and enjoy solving puzzles, and to typical intellectual engagement (a similar construct to need for cognition).

The teenage Freud may have been able to extend effort in idea production, an aspect of creativity according to Sidney Parnes.

The teenage Freud may have been a person who defied conventions, was independent in judgment and thinking; he may have been discontented, attracted to unconventional thinking, a fault finder, and stubborn and temperamental: all aspects of the creative personality according to Torrance.

The teenage Freud may have shown a desire for discovery, and a striving for general principles: aspects of creativity according to Taylor.

The teenage Freud may have been complex psychodynamically with a high level of psychological scope; he may have been assertive and dominant: aspects of creativity according to Barron.

The teenage Freud may have been adept at mental pattern recognition, an ability to see meaning in behaviors, ideas and emotions that present as a seeming maze of indiscriminate personal facts: mental pattern recognition is a cognitive ability associated with creativity.

The teenage Freud may have been independent in his cognitive abilities and have valued these abilities very much; he may have been a person who was able to hold many ideas in his mind at once; he may have seen a more complex universe than many people: aspects of creativity according to Barron.
The teenage Freud may have been a person who became aware of unconscious motives and fantasy life, an important feature of the creative thinker, according to Barron.

The point is that Freud would have had these traits regardless of whether he became a lawyer or a conventional medical doctor or a psychoanalyst. Before he became a psychoanalyst Freud was simply an ordinary person with a cluster of certain personality traits.

The important question is whether these traits are relevant or irrelevant to the way a therapy patient does therapy. Will a creative patient respond to the therapist the same way a noncreative patient will respond?

If Freud were 18 years old and in therapy, what kind of patient would he be?
Brief Summary of My Family Dynamics

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 in 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.

There was a lot of marital discord between the patient’s parents. In the patient’s early years (up to age 12) there was serious and continual discord centering on the father’s inability to serve as an adequate provider and the fact that mother was a Catholic and father had an Orthodox Jewish background. All of the family members showed extreme individual narcissism, especially the mother’s older sister who was flagrantly grandiose. The mother’s sister once said to the patient: “I gave you everything you have. If it had been up to your father you would have had shit!”

The father had a violent temper. He used to beat the patient with a belt or cat ‘o nine tails when the patient was a boy. On one occasion the father attempted to murder the mother by strangulation in front of the children.

At least as it related to the patient, the mother was a negligent caretaker.

The mother’s mother (patient’s grandmother) was a paranoid and dysfunctional individual who was intensely and obsessively anti-Semitic. She emigrated from Poland at age 18 but never learned more than rudimentary English. In the mother’s family of origin there was
severe role reversal, with the mother’s older sister having to assume a parental role in early childhood to compensate for the grandmother’s inadequacy. The mother’s family of origin struggled with extreme poverty in the days before social welfare programs: mother reported that there were many days when there was nothing to eat but rice boiled in milk.

There was a lot of parental favoritism in the patient’s family. The daughter, patient’s older sister, was assigned the role of good child. The patient was assigned the role of bad child, or scapegoat. The mother’s sister idealized patient’s sister but maintained a degrading and aggressive manner with the patient. Mother’s sister was contemptuous of the father, often referring to the father as a “louse” in front of the patient. Because of the mother’s dependency on her older sister she was psychologically incapable of protecting her son from her sister’s aggression against him.
THERAPIST: Tell me, who are some of your heroes?

PATIENT: Well, I would say . . . Gandhi, Martin Luther King, . . . Leon Trotsky.

THERAPIST: Leon Trotsky? Why Trotsky?

PATIENT: He defied Stalin.

THERAPIST: Weren't all those people assassinated?

PATIENT: Yes.

THERAPIST: No wonder you have problems with people!

THERAPY SESSION: MAY 23, 2018

In this communication I attempt to show how my ideas about therapy and psychoanalysis are rationalizations of my personality needs. I also attempt to show how the work of an attachment-oriented therapist – specifically, the therapist's particular interpretation of attachment theory – may be, to some extent, a rationalization of that therapist's personality needs.

I have identified certain personality needs or attributes that seem to underlie my use of psychoanalysis, or the comfort I experience by looking at myself through a psychoanalytic lens.

1. Insecure attachment: I have an insecure attachment style. I am dismissively avoidant and feel more comfortable in the life of the mind than with social relations. I am socially anhedonic and don't experience the pleasure that securely attached persons derive from social relations. I am creative and independent in thought and action. I am able to “risk nonconformity.” See Codato, M. and Damian, R. “Creativity and Nonattachment: A Relationship Moderated by Pride.” Testing, Psychometrics, Methodology in Applied Psychology, 20(2): 185-195, June 2013 (Rodica Damian was a graduate student of Phillip Shaver's at the
Creativity, conceived as the ability to produce work or ideas that are original, high in quality and appropriate implies the capacity to “risk nonconformity” and a sort of freedom from the reactions generated by one’s products – to some extent creativity may involve a certain disengagement from personal attachments (or an ability to make adaptive use of a lack of secure attachment). To some extent one can trace many of my social difficulties to a conflict between people of differing attachment needs: as someone who can readily “risk nonconformity” I face the most severe interpersonal problems with people who, because of their attachment style, cannot “risk nonconformity” – these individuals need the safety of conformity in order to preserve their personal attachments. It's a dubious cliché for a therapist to say to me “You need to take risks with people.” Many of the people with whom I have severe problems are those socially-adjusted individuals who can't risk asserting their individuality – and in so doing risk a needed social source of identity and security, or to put it in more technical terms, they can't risk losing the social defense against intrapsychic anxieties that group membership affords. We see this as an important aspect of my therapy relationships. I suppose that many patients want to be liked by their therapists, and will feel the need to ingratiate themselves with them or avoid displeasing them. It is well to keep in mind, my favorite therapist (Stanley R. Palombo, M.D.) on different occasions called me a “freak” and a “buffoon.” I didn't care. My attachment insecurity seems related to the fact that my thinking, behavior, and values are not driven by a need for social approval – a need that one might find in securely-attached persons.

It has been found that rejection may not merely be a result of the unconventionality of creative people but that the actual experience of rejection may promote creativity, with the effects depending on a person’s self-concept. For those who are highly invested in belonging to a group, rejection may constrain them and trigger an attachment response. But for those scoring high in a need for uniqueness, the negative consequences of rejection on creativity may be mitigated and even reversed. For creative people, rejection does not necessarily trigger the attachment response; it may trigger creativity and self-esteem. Kim, S.H. et al. “Outside Advantage: Can
Social Rejection Fuel Creative Thought?" These findings add a complication to attachment theory and may pose a problem for attachment therapists.

My attachment style seems related to my moral reasoning. In the view of Lawrence Kohlberg conventional morality is based on the importance of interpersonal relationships. In this stage one tries to conform to what is considered moral by the society that they live in, attempting to be seen by peers as a good person, i.e., they will attempt to harmonize their moral values with the need for social acceptance. My moral reasoning seems related to my diminished need for social acceptance. If a group embarks on a course of action that is contrary to my values, I will not follow the group and subvert my values in the interest of social acceptance. (In the therapy situation, I will not stop writing letters because it risks the disapproval of the therapist.)

Perhaps there is a relationship between attachment style and the willingness of the whistleblower to take the risks. It has been observed that “Whistleblowers blow the whistle because they dread living with the corrupted self more than they dread living in isolation from others.” Alford, C.F. Whistleblowers: Broken Lives and Organizational Power. According to Alford, moral narcissists strive to live up to their introjected values 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.” Perhaps, individuals such as Gandhi (who engaged in hunger strikes) and Martin Luther King, Jr. were individuals with attachment anxieties who could risk social opprobrium in the interest of staying true to their introjected values. Such individuals are more concerned with introjected values (see Paragraph 3, below) than with social relatedness. See Martin Luther King, Jr., Speech at Western Michigan University (Dec. 18, 1963) (discussing the importance of “creative maladjustment”).

Finally, it is important to define precisely the psychological state I experience when alone: (1) Do I feel uncomfortable being alone and experience loneliness?; (2) Is my alone state a defensive reaction to fears of rejection associated with insecure attachment; or (3) Do I have the capacity to be alone because of ego maturity. See Winnicott, D.W., “The Capacity to Be Alone.” Int. J. Psycho-Analysis, 39:416-420 (1958). According to Winnicott, the
capacity to be alone, which is a “mature” internal development on the part of the infant, is a principle component in the development of creativity. The capacity to be alone is manifested in the child as a condition of unintegration, and in the adult as relaxation, although both of these states may be more aptly described as authenticity. In this authentic state, according to Winnicott, the child, adolescent, or adult “is able to exist for a time without being either a reactor to an external impingement, or an active person with a direction of interest or movement.” Is my letter writing a defensive way of coping with loneliness? Is my letter writing a substitute for personal relationships? Or is my letter writing a creative act emerging out the capacity to be alone, and therefore an expression of ego maturity?

2. Reaction formation against anality: I may show rigid reaction formations against anality. “A not infrequent accompaniment [to repressed greed] is pretended contempt for money in real life and ‘moral narcissism,’ that is, yearning to be pure, free of attachment, and above ordinary human needs. Disenchantment with food to the extent of developing anorexia nervosa (compare “Gandhi's hunger strikes,” see Paragraph 1, above) is often the consequence of such narcissism and repressed [anal] greed.” Salmon Akhtar, Sources of Suffering: Fear, Greed, Guilt, Deception, Betrayal, and Revenge at 40 (2014). My highly-developed moral sense might be a reaction formation against anality. For example, when I applied for Social Security Disability benefits in 1993 I told the SSA in writing, “I believe I am employable.” I was absolutely honest with SSA and did not claim to have a disorder or claim that I was disabled. I reported that it was others who had said I had mental problems and that I was unemployable. I told SSA that I believed I was absolutely able to work. Precious few disability claimants would admit that to SSA.

My absorption in the life of the mind may reflect my need to immerse myself in pursuits detached from ordinary human needs, reflecting a reaction formation against anality. My interest in psychoanalysis – an intellectualized endeavor – may in part be rooted in this defensive need.

3. Introjective Depression: I take pride in my thinking and view my personality problems not simply as mental pain, but also as a puzzle to be
solved. I need others as an audience to observe and applaud my grandiose ideas about my personality. My introjective disorder is aggression based. I am much more concerned about self-assertion and aggression than about bonding and relatedness. Blatt, S.J. “Representational Structures in Psychopathology.” Introjective depression is viewed as a structural outcome of a developmental environment in which important attachment figures have been controlling, overly-critical, punitive, judgmental, and intrusive. Blatt, S. J., & Shichman, S. “Two primary configurations of psychopathology.” *Psychoanalysis & Contemporary Thought, 6*(2), 187-254 (1983).

Strengthening the therapeutic alliance is particularly difficult among introjective patients because they tend to have punitive, harsh representations of self and others, which are likely to be projected onto their therapist. Introjective patients will not respond well to therapists who focus on emotional support and gratification of nurturant needs. Introjective patients are unlike clients preoccupied with issues of dependency, abandonment, and feelings of helplessness who are more invested in connection, and nurturing a collaborative relationship with their therapist—indeed it is through the lens of relationship (as opposed to self-definition) that they see themselves and navigate their world. Put another way, in the relative absence of these preoccupations (i.e., among introjectives), a therapist should perhaps feel less compelled to cultivate and invest in a collaborative relationship. Kemmerer, D.D. “Anaclitic and Introjective Personality Distinctions among Psychotherapy Outpatients: Examining Clinical Change across Baseline and Therapy Phases.”

It is vital to understand that my personality problems do not center simply on the lack of relationships but the presence of severe introjective issues. Drew Westen has made an interesting observation about anorexic patients. “If their attitudes toward their needs and feelings in general (and not just toward food) do not become the object of therapeutic attention, they are likely to change with treatment from being starving, unhappy, isolated, and emotionally constricted people to being relatively well fed, unhappy, isolated, and emotionally constricted people.” Westen, D. and Harnden-Fischer, J. “Personality Profiles in Eating Disorders: Rethinking the Distinction Between Axis I and Axis II.” This is somewhat applicable to me as someone
who is both socially isolated and struggling with introjective depression. If my attitudes toward my needs and feelings in general (and not just toward social relations) do not become the object of therapeutic attention, I might change with treatment from being unhappy, isolated, and emotionally constricted to having improved social adjustment but still struggling with depressive states around feelings of failure and guilt centered on self-worth: an individual who remains perfectionistic, duty-bound, and competitive, who feels like he has to compensate for failing to live up to unreasonable introjected standards.

Perhaps an analogy might be useful. Reduced blood flow to the heart will cause a heart attack, resulting in the death of heart tissue and the development of scar tissue. Even if blood flow is restored, the scar tissue will remain. Think of blood flow as analogous to social relations, and reduced blood flow as analogous to attachment problems. Then, think of the scar tissue as analogous to introjective problems that will remain even if social relations are improved.

From an adaptive standpoint it is well to keep in mind that creative personalities score highest on aggression, autonomy (independence), psychological complexity and richness, and ego strength; their goal is found to be "some inner artistic standard of excellence," that is, introjected values. MacKinnon, D. W., "Personality and the Realization of Creative Potential." *American Psychologist* 20: 273-81, 1965.

4. Extravagant Need for Transitional Objects: It may be useful to see me as a 64-year-old man who is desperately tied to a symbolic teddy bear or comfort blanket. It's as if my intellectual pursuits were symbolic transitional objects. In therapy it would be useful to look at why I have a desperate need for transitional objects and what that says about my relationship with my mother.

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 – namely, 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.” Lerner, H.D. and Ehrlich, J. Psychodynamic Models.
In therapy, the question is “How does my extravagant need for symbolic transitional objects relate to my personality and my relationship with my mother?”

**THOUGHTS ABOUT HOW AN ATTACHMENT-ORIENTED THERAPIST MIGHT USE ATTACHMENT THEORY TO RATIONALIZE HER REGRESSED, UNCONSCIOUS PSYCHOLOGICAL NEEDS**

(I am not making any representations about my therapist's personality. I am simply offering thoughts about how an attachment-oriented therapist might rationalize certain personality traits through the use of attachment theory.)

My therapist says she isn’t interested in categories and labels. She has said she does not believe in the diagnostic category, borderline disorder. She seemed to show no interest in my psychological test results. My subjective feeling is that she engages in a persistent assault on my individual identity. She has attacked Freud and psychoanalysis as lacking in compassion — as if the role of the therapist were to nurture the patient. She employs attachment theory: a theory that focuses on the infant’s relation with mother — keep in mind, infants have no firmly developed identity, that is, no conflicts, defenses, or internal prohibitions. Infants are simply a bundle of biological needs and rudimentary personalities. Infants are undifferentiated. They do not have the highly-developed character organization or particularized personality needs seen in adults.

*Random thoughts:*

The young Freud was fascinated with Darwin’s work. ([When I was a teenager,] the theories of Darwin, which were then of topical interest, strongly attracted me, for they held out hopes of an extraordinary advance in our understanding of the world[.]*) Think about the title of Darwin’s celebrated book, “The Origin of Species.” Darwin could have called his book, “The Origin of Biological Categories.” Darwin was interested in labels
and categories. *Darwin created organization.*  Freud was fascinated with Darwin.

Freud coined the term “psychoanalysis” from chemistry.  Apparently, he saw a connection between the analysis of personality and chemical analysis.

Several of my psychiatrists have said, “I don’t believe in the DSM.  All people are unique.  We need to see people as individuals.”  I think of chemistry.  Each chemical element is unique.  Each chemical element has a unique atomic number.  Mendeleev had the insight that if you arrange all the elements in a particular way, they fall into “periods” or categories (The Periodic Table of the Elements).  Mendeleev created categories.  *Mendeleev created organization.*  The DSM reminds me of the Periodic Table.  Patients are unique, but they fall into diagnostic categories.

Is it simple coincidence that Freud had a fascination with Darwin and apparently thought in terms of chemistry — and that my personality resembles Freud’s in important ways?

I think of the following:

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. — is 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 (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 psychoanalyst Bela Grunberger saw an expression of anal sadism in the treatment by the Nazis of concentration camp inmates. Inmates were identified by numbers rather than by names. “The anti-Semite’s specific [anal] regression is most clearly seen in his representation of the Jew. 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.”

Dr. Shengold seems in accord: “‘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.” Shengold, L. Soul Murder: The Effects of Childhood Abuse and Deprivation.

The psychoanalyst Jessica Benjamin seems to imply a possible deep connection between the anal sadistic urge to denude another of identity, on the one hand, and a perverse interpretation of attachment theory, on the other, as it relates to issues of mother-infant bonding.

I am not attacking attachment theory, which stands on its own as a valid perspective. I am not attacking attachment-oriented therapists.

But I wonder about the attraction of attachment theory to certain therapists of a particular personality type:

Is attachment theory particularly attractive to therapists with an unconscious anal sadistic trend who are pathologically tied to mother? I had the intuitive feeling that my past therapist was persistently attempting to nurture me. Was my therapist determined to undo my identity in an attempt to define her own identity? Isn’t that psychologically exploitive? Isn’t that what happens in cults? The cult leader defines himself by stripping cult followers of their distinct identities in the process of subjugating cult members to an
indissoluble bond. In the cult the implicit connection between identity and attachment seems manifest. Do cult members represent the symbolic mother for the leader from whom the cult leader is psychologically unable to separate?

“Chassevet-Smirgel's interpretation of sadism as the de-differentiation of the object by alimentary reduction does not fully elaborate the function of anal sadism for the self in relation to other. Her analysis emphasizes only one side of the sadistic act. The act aims not only at de-differentiating the self: the self imagines that in reducing the other it is establishing its own identity. Because it imagines that in digesting the other it is nourishing its own identity, its effort to gain control over the other actually represents an effort to separate, to achieve its own autonomy. The paradigmatic other [such as the followers of a cult leader] who is being reduced is the mother, from whom the sadist [or cult leader] feels unable to separate.” Benjamin, J., Like Subjects, Love Objects: Essays on Recognition and Sexual Difference.

May we say that for some attachment therapists the patient is the symbolic mother, and that – in a parallel process – the therapist rationalizes the use of attachment theory in clinical practice to work through her personal issues of control and separation, denuding the patient of individual identity in an effort to achieve her own autonomy? Would such a therapist denigrate the patient's struggle for personal identity and view the patient's use of categories and labels as antithetical to her regressed need to undo organization and nourish her own identity and gain control of the patient? One wonders?

I am concerned about what regressed psychological needs of a therapist are gratified by reducing an individual to the simple needs for unconditional acceptance and emotional responsiveness by another. Mother-infant attachment is fundamental and necessary to adult functioning but it is not sufficient to understanding the needs of an adult. I will venture to say that in any science, rudimentary aspects of a phenomenon are fundamental and necessary to understanding the phenomenon but will likely not be sufficient. For example, the biochemist knows that a fundamental and necessary part of understanding biochemical processes is a firm grounding in basic inorganic chemistry – but it is not sufficient. In attempting to understand any complex
system – and the personality is a complex system – reductionism will not necessarily provide a sufficient explanation for a problem.

The fundamental conundrum I grapple with is why a therapist would find it psychologically gratifying to apply a reductionist approach to understanding problems of personality and social adjustment that involves denuding a client of what makes him a singular individual with particularized needs and character organization. Might some attachment-oriented therapists have an unconscious, irrational agenda in doing so?

There is some circumstantial evidence that attachment theory might have a special appeal to therapists who have an over-idealized view of motherhood. John Bowlby, originator of attachment theory, himself might have had attachment anxieties and his theory might have grown 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.

The following is an email exchange I had with Phillip Shaver, Ph.D. at the University of California, Davis. Dr. Shaver is one of the world's foremost authorities on attachment theory. He has authored more than 300 books and articles on the subject as well as the definitive 1,000-page text on attachment theory. Rodica Damian, whose work was cited above, was a graduate student of Dr. Shaver's at UC-Davis. Rodica Damian et al. observed: “Creativity, conceived as the ability to produce work or ideas that are original, high in quality and appropriate implies the capacity to “risk nonconformity” and a sort of freedom from the reactions generated by one’s products – to some extent creativity may involve a certain disengagement from personal attachments (or an ability to make adaptive use of nonattachment).”

Dr. Shaver can be reached at 530-752-1884.
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? What about the uniquely human aspects of the human animal — issues addressed by psychoanalysis? 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. Yes, the human animal, like the monkey, can be reducible to science. But the human mind is neither reducible in its entirety to a science nor to a mystery, but encompasses elements of both.

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—that is, psychic derivatives of biology) 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 exhibits 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
I 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 scapegoating of creative outsiders who pose a threat to group cohesion. In short, there is no guarantee that all features of biology are adaptive. Another example: African populations who moved to Europe eons ago lost their skin pigmentation that allowed these European populations to more easily absorb vitamin D at higher latitudes. With that biological
advantage there arose a disadvantage: the greater risk for skin cancers in these northern populations. We should emphasize 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).

It’s virtually meaningless and deceptive for attachment therapists to propose that secure attachment is an ideal to which all must aspire. The issue is what one is comfortable with. Is the individual happy to be insecurely attached with a lessened need for social bonding and relatedness but a superior ability to tolerate being alone with the concomitant ability to nurture his creativity?

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. Secure attachment is not all good and insecure or anxious attachment is not all bad. As the CBT practitioner likes to say: black and white thinking is a cognitive distortion.

Gary Freedman
Washington, DC

Reply from Dr. Shaver. Significantly, Dr. Shaver emphasizes that “no one in the attachment field ever claimed that attachment is everything” and that insecure attachment is as valid an attachment style as secure attachment. Whether any attachment style is “good” or “bad” depends on the individual’s circumstances – whether the attachment style is adaptive to his environment and ego-syntonic. Dr. Shaver would say to an avoidant individual, “If you are an insecurely attached individual who likes to spend time alone listening to Beethoven on his iPod while watching people walk down the street on Connecticut Avenue, there's nothing wrong with that.”

From: Phillip R. Shaver
To: Gary Freedman
Sent: Sun, Nov 19, 2017 2:49 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 attachment 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

Reply from Gary Freedman:

On Nov 19, 2017, at 11:27 AM, Gary Freedman <garfreed@netscape.net> wrote:

Thank you so much for your thoughtful and useful reply. I have been led astray about attachment theory by my very socially-oriented relational therapist who seems unable to see anything positive about my avoidant, independent-minded traits. Thanks again for the information. I'll have to read more!!

Gary Freedman
Washington, DC

Reply from Dr. Shaver:

-----Original Message-----
From: Phillip R. Shaver <prshaver@ucdavis.edu>
To: Gary Freedman <garfreed@netscape.net>
Sent: Sun, Nov 19, 2017 2:49 pm
Subject: Re: SPN Profile Message: problems with Bowlby

Sounds good. One’s view of these matters depends on one’s values, which are in turn somewhat related to one’s attachment history. Therapists are generally interested in how a person’s history, including family history, has
led to a person’s current problems. If an anxious or avoidant person has made a series of happy life choices that fit with his or her attachment orientation, he or she will not show up for therapy, so therapists need not worry about those successful adaptations. (I’ve always thought that an avoidant person might be a good spy, for example, because he could go somewhere alone, maintain a fake identity, and take advantage of people without feeling too bad about it. But he might also become a double agent without guilt, as has often happened with actual secret agents.) Therapists are generally trained to notice when symptoms are or are not “ego-syntonic.”

For example, Donald Trump obviously qualifies as having a narcissistic personality disorder, but there’s no indication that this bothers him, makes him unhappy, or keeps him from succeeding in life. As with avoidance, however, narcissism may not be good for one’s close relationship partners, as we see with The Donald’s three wives and many cheated and abandoned business partners. A less extreme example is Steve Jobs. I’m typing on one of his wonderful products, but he was often hell to live and work with.

Sent from my iPhone

FINAL THOUGHTS – GOALS IN THERAPY

Any therapist reading this letter might well ask: “If you are happy sitting alone on a park bench listening to Beethoven on your iPod, what do you want to accomplish in therapy?”

I would like to work on the following issues:
I would like to become more fully who I am. I would like to grow as a whole person. I would like to work on my psychological distress – depression, anxiety, relationship difficulties, and the like.

I would like to develop insight about the ways in which I distance myself from painful thoughts and feelings (dissociation), repeat old relationship patterns, and prevent myself from fulfilling my potential.

Specific symptoms that I need to work on are dissociation; masochism (an ascetic trend not unlike anorexia nervosa in which I disdain pleasure); the inability to derive pleasure from social relations; my extravagant narcissistic need for twinship, idealization and mirroring that has led to disastrous consequences for me – as well as the flip side of the coin, namely, my intense feelings of alienation when I am around people who cannot satisfy my narcissistic hunger for self-sameness; my lack of interest in social relations (metaphorically, I would like to experience hunger); and why it is that I serve – and seem to need to serve – as a repository in groups.

ADDITIONAL THOUGHTS ABOUT DR. SHAVER'S 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 psychoanalysis and 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.
THERAPY SESSION: May 29, 2018

At the outset of the session on May 29, 2018 I stated my goals in therapy as follows:

*I need to work on dissociation; masochism (an ascetic trend not unlike anorexia nervosa in which I disdain pleasure); the inability to derive pleasure from social relations; my extravagant narcissistic need for twinship, idealization and mirroring that has led to disastrous consequences for me – as well as the flip side of the coin, namely, my intense feelings of alienation when I am around people who cannot satisfy my narcissistic hunger for self-sameness; my lack of interest in social relations (metaphorically, I would like to experience hunger); and why it is that I serve – and seem to need to serve – as a repository in groups.*

We will return to this issue later.

Thereafter I told the therapist that the previous November my therapist had given me a mini-lecture on attachment theory, that my therapist’s comments aroused my curiosity about attachment theory, and that I began to read about attachment theory. I formed questions and concerns about attachment theory — concerns about basic tenets of the theory. I said that I found the name of a leading expert (Phillip Shaver) on attachment theory and sent him an email I had written discussing my critical comments about the theory. I said that I was surprised that a few hours later Dr. Shaver responded to me with substantial comments about my email, and elaborated aspects of attachment theory. My therapist and I discussed the fact that Dr. Shaver had offered comments about attachment theory that seemed to contradict the therapist’s seemingly deeply held ideas about attachment theory, namely, that secure attachment is the ideal type of attachment to which everybody should aspire. The therapist explained that perhaps Dr. Shaver’s views were not all that different from her own.

The therapist and I got into an intellectualized discussion about the content of Dr. Shaver’s email. The therapist showed no interest in the relational aspects of my communication with Dr. Shaver, such as, “How did you feel about
At a later point in the session, the therapist said, “You think you’re smarter than everybody else.”

At another point in the session, I told the therapist an anecdote to illustrate my problems with peers. “When I was in my second year of college, I took an introductory course in public speaking. We had to give three speeches during the course of the semester. After one of my speeches the instructor said that my speech was the finest speech any student had given in about the last three semesters. Then in my next class — I remember it was biological science, a large lecture hall class — there was a student who had been in my speech class. He was sitting across the lecture hall and yelled out to me, ‘You are so weird, man! You are so totally weird!’”

Why did my peer have a negative reaction to me? Is it that I gave the impression that I thought I was smarter than everybody else? Or was it that an instructor had singled me out for unusual praise in a class in which some students struggled with stage fright? Was there an element of jealousy in the student’s negative response? Compare the situation at this therapy session: I told the therapist that one of the world’s leading authorities in attachment theory — the therapist’s own field — had “singled me out” by responding to my layman’s critique of attachment theory and that Dr. Shaver had offered comments about attachment theory that seemed to contradict the therapist’s seemingly deeply held ideas about attachment theory, namely, that secure attachment is the ideal type of attachment to which everybody should aspire.

But there is another issue relevant to appraising my peer’s negative response to me. I told the therapist about the topic of my speech that had been singled out for praise. I had told my college class that people should not seek pleasure in life, that a person should just live and if one finds something pleasurable he should enjoy the experience, but that he should not make pleasure-seeking his goal in life. These are peculiar ideas for an 18-year-old
to express. Most teenagers are pleasure-seeking creatures. They live for pleasure. In fact, my instructor commented: “You must be a lot of fun at parties!” Did my fellow student, my peer, react negatively to my thinking, my rationality and my individuality? Was the fellow student’s negative reaction to me fundamentally a negative reaction to my autonomy and the fact that I expressed values inconsistent with those held by most teenagers?

A digression:

I have had severe interpersonal problems in the workplace. Were these problems caused by my grandiosity and narcissistic self-inflation? Did I think I was smarter than everybody else? Was that the cause of my problems? I was terminated days after I lodged a harassment complaint against a racist supervisor. The employer later alleged in an apparently perjured sworn statement that I was fired because of severe mental problems: reportedly, I had delusions of persecution, frightened my coworkers, was potentially violent in the opinion of a psychiatric consultant, and — according to my direct supervisor — potentially homicidal. (The employer never contacted the police, by the way!)

I can’t say with certainty why I had problems in the workplace, but group theory offers a tantalizing explanation.

According to Otto Kernberg, M.D. individuals in groups tend to develop a group identity and subvert their individuality in the interest of homogenization and group cohesion. Individualists will be targeted for aggression in cohesive groups in which group members have become an undifferentiated mass. In group theory it’s called “massification.” Dr. Kernberg writes: “[Group theorists] describe the complete loss of identity felt by the individual member of a large (unstructured) group.” “[Group theorists] also describe the individual’s fears of aggression [as in, “I am afraid he is going to kill me”] from other members, loss of control, and violent behavior — fears that can emerge at any time in the large group.” “Gradually, it becomes evident that those who try to maintain a semblance of individuality [i.e., those who retain their autonomy and identity — in a sense, those who will not be reduced to the status of an undifferentiated infant] in
this atmosphere are the ones who are most frequently attacked.”  “For the most part aggression in the large group takes the form of envy — envy of thinking, of individuality, and of rationality.” Kernberg, O.F. “Ideology, Conflict, and Leadership in Groups and Organizations.” Dr. Kernberg can be reached at +1 914 997 5714. The late Gertrude R. Ticho, M.D., my former employer’s psychiatric consultant, whose professional opinion about me was the basis of the Social Security Administration’s disability determination, was a personal friend and professional colleague of Dr. Kernberg’s.

Query: Are my problems with therapists and with peers the result of my narcissistic belief that I am smarter than everybody else or that I tend to retain my thinking, my individuality, and my rationality in the face of group oriented people (including therapists) who want me to regress to the state of an undifferentiated infant who has no thinking, no individuality and no rationality?

There is another tantalizing question raised by group theory about my therapist’s reaction to me. Group theorists maintain that helplessness and the fear of annihilation precede the emergence of envy in some groups. Hopper, E. “The Theory of the Basic Assumption of Incohesion: Aggregation/Massification or (BA)I:A/M. Return for a moment to the opening of my therapy session. I told my therapist my goals in therapy. Are these issues that my therapist is able to treat? How do you use attachment theory to help a patient experience “hunger” if he doesn’t feel hunger? Indeed, in the remainder of the session the therapist never addressed the issues of my lack of social “hunger” and feelings of alienation, but continued to pursue the issue of approach avoidance. Is it possible that the therapist had unconscious feelings of helplessness along the lines, “How in the world do I treat these issues? There is no way for me to help this patient if these issues are in fact his problem?” Did the therapist’s unconscious feelings of helplessness trigger her possible feelings of envy of me that took the form: “You think you are smarter than everybody else?”

Is it possible that the therapist was thinking at some level: “You are able to help me help you, but you are not cooperating with me. You resist me and thwart me.”
Group theorist Earl Hopper offers insight into the possible psychodynamics of such thoughts: “Malign envy is directed towards objects who are perceived as able but unwilling to help, and who are perceived as responsible for failed dependency, that is, failed containment, holding and nurturing. In other words, according to this perspective, malign envy is not innate, but develops as a defence against feelings of profound helplessness, which are a consequence of traumatic experience.” Traumatic Experience in the Unconscious Life of Groups.

Interesting coincidence: On one occasion my former treating psychiatrist, Stanley R. Palombo, M.D. pointed out that I seemed to have struggled with others’ feelings of jealousy. No other therapist I have subsequently seen in the last 26 years has ever mentioned that. Dr. Palombo was an individual thinker who never showed any trace of jealousy or envy of me. He was also the only therapist who had undergone a training analysis and was aware of, and able to control, his baser instincts.

Again, is a fundamental problem for me in therapy and life that I retain my individuality, my thinking, and my rationality in the face of the needs of group-oriented people?

RANDOM THOUGHTS TRIGGERED BY THE THERAPY SESSION:

The following ideas will provide clues about my unconscious and conscious internal working model and the nature of my relationship with my mother including my pre-representational experience. A careful assessment of these ideas is important from an attachment model perspective. From a psychoanalytic perspective, I suppose these ideas help define the nature of my orality.

I often think of a line from a poem: “Hearts starve as well as bodies; give us bread but give us roses.”

I have asked social workers the following question. They have no answer.
This is what I want to know: Psychoanalysis takes a tremendous investment of time and money. Interestingly, most of the people in analysis are more or less socially adjusted. Obviously, there are people in analysis who are struggling with more than loneliness or social isolation. My question is always: “OK, let’s say I have friends. Then what?” Social workers can’t answer that. Isn’t life what happens after you’ve had your fill of bread?

___________________________________________

**What rationalizations will a glutton use?**

Perhaps a glutton would say: “People need food. That’s basic biology. You can’t live without food. If you don’t eat, you’ll die. People will die of starvation if they don’t eat.”

**What will a medical doctor say to a patient with anorexia?**

“People need food. That’s basic biology. You can’t live without food. If you don’t eat, you’ll die. People will die of starvation if they don’t eat.”

If a therapist says: “You need to have friends.” Or “It’s vitally important that you make an effort to have friends,” what is his unconscious agenda? THAT’S THE QUESTION: Is he rationalizing his pathological attachment to his mother — or is he talking from the perspective of an independent and mature person about legitimate needs.

Interesting point. Attachment theorists point out that there are conscious working models of relationships but also unconscious working models of relationships.

Research has shown there are teenagers who have an active social life with lots of friends who are in reality insecurely attached. Their social relations are defensive: they are kids who have poor unconscious attachment to parents (or disturbed unconscious internal working models) with a lot of attachment anxiety and they pour themselves into a tightly-knit peer group as a defensive reaction to unconscious attachment insecurity. Perhaps these dynamics are useful in understanding teenage gangs. Many gang members come from
disturbed family backgrounds that may have promoted insecure attachment; the gang members defensively form powerful attachments with each other, that is, seemingly secure attachments that belie the members’ underlying insecure attachment style.

I have the feeling there are some social workers who come from that cohort, namely, individuals who have an adaptive (but defensive) attachment style with attachment insecurities that can be seen upon assessment of their unconscious internal working model.

Dr. Kernberg’s observations about the psychodynamics of dysfunctional groups raise intriguing questions about the problems of a creative individual in groups: a creative person for whom “sucking at the mother’s breast” is not the be-all and end-all of his existence. “The psychology of the group, then, reflects three sets of shared illusions: (1) that the group is composed of individuals who are all equal [think of a group of undifferentiated infants in a maternity ward], thus denying sexual differences and castration anxiety; (2) that 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.”

To what extent does a social worker’s view of the therapy dyad reflect unconscious notions of a group ideal in which the client’s singular identity is to be expunged and the therapist assumes the role of the “idealized breast mother” who cures through the client’s consumption of her milk? “My technical expertise doesn’t really matter. It’s whether you can form a relationship with me in which you accept what I say.”

QUERY: An adult client internalized sets of trauma-related ideation from his mother, which remain unintegrated in his self-structure and cannot be reflected on or thought about. How can this client be treated without some type of expertise? See, Fonagy, P. “The transgenerational transmission of
I have the impression that the underlying agenda of some social workers is basically: “You want friends. I know you want friends. You need friends. You need to make an effort to have friends.”

What do I hear when a social worker says this?

I hear a mother talking to her infant: “You want the breast. I know you want the breast. You need the breast. You need to make an effort to suck on my breast.”

Life for me is — and perhaps has always been — what happens after I suck on the breast. The breast has never been my be all and end all. Most people live for the breast. I don’t. What I need are friends who don’t live for the breast.

For me life was always what happens when mommy leaves me in my crib!! For me life is and, perhaps was always, what happens when I’ve “had my fill of bread?” I yearn for the roses.

What do attachment theorists say about this? I don’t know. I can tell you what psychoanalysts have said about creative people.

“[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.”

For the creative individual life is more than bread, it’s about the roses.

I suppose you can dismiss all this as psychoanalytic mumbo jumbo. Except for one salient fact: The psychoanalytic term “regression in the service of the ego” has been adopted by attachment theorists and is now a mainstream idea in attachment theory. Zimberoff, D. and Hartman, D. “Attachment, Detachment, Nonattachment: Achieving Synthesis.”

The authors write:

Here we will briefly examine the concept of openness to experience, and its association to that of “freedom to explore the external and internal worlds.”

The construct of openness to experience has its roots in the psychoanalytic and humanistic approaches to personality, and represents tolerance for the unfamiliar, interest in ideas and problems, and appreciation of experiences involving actions, fantasy, values, feelings and aesthetics (Tesch & Cameron, 1987). Schachtel (1959) proposed the concept of openness to experience, derived from the concept of regression in service of the ego, to mean a loosening of fixed anticipations so that one approaches the objects of his/her experience in different ways, from different angles.

Openness to experience was first empirically applied by Fitzgerald (1966), who found that college students scoring high in openness were low in repression on the MMPI. He depicted the following aspects as components of openness to experience (derived from the concept of regression in service of the ego):
• Tolerance for regressive experiences (affects, childishness, fantasy, daydreaming, etc.) [Note how some CBT practitioners might have a problem with this feature.]

• Tolerance for logical inconsistencies (seeming impossibilities or bizarre implications) [Note how some CBT practitioners might have a problem with this feature.]

• Constructive use of regression (uses fantasies in a creative way) [Note how some CBT practitioners might have a problem with this feature.]

• Altered states (inspirational experiences with relative breakdowns of reality orientation)

• Peak experiences (seeks experiences which are overwhelming, enrapturing, and thrilling)

• Capacity for regressive experiences (inquisitive into the unusual, with rich imagination, and not bound by conventional categories of thought)

• Tolerance for the irrational (acceptance of things which violate common sense or science) [Note how some CBT practitioners might have a problem with this feature.]

Fitzgerald, based on his research, concluded that openness to experience has a somewhat different meaning for males and females. Males who are open to experience are open to inner (controlled) experience; females who are open to experience are open to outer (expressive) experience. Coan (1972) observed that people vary considerably in the range and types of experience to which they are open, and also that a given individual can be very open in one area of experience while being very closed in another area. He also noted that women tend to be more open in the realm of feeling and thought, while men tend to be more open in the realm of action. Openness to experience is a basic and stable aspect of personality that can be detected and quantified (McCrae & Costa, 1982; Tesch & Cameron, 1987). They operationalized openness to experience as non-defensiveness, willingness to share
experiences, openness to the unknown and unknowable, to emotions, ideas and spirituality, and to seeming incompatibilities. [Note how some CBT practitioners might have a problem with this last feature.]

Consider the similarity of the openness traits already stated to these attitudes of secure persons (Mikulincer & Florian, 1998):

• Engagement in information search

[compare a gifted patient’s insatiable search for information]

• High tolerance for unpredictability, disorder, and ambiguity

[note how this may pose a problem for some CBT practitioners]

• Reluctance to endorse rigid beliefs

[Note how this may pose a problem for some CBT practitioners. “You need to have friends. You have a fear of rejection and loneliness. You need to take risks. I will show you how your simple cognitive distortions prevent you from attaining these goals.” But I never said that was my goal!]

• Tendency to integrate new evidence, to revise beliefs in the face of new information

• Describe themselves in positive terms yet admit negative self-attributes

• Optimistic attitude toward life and basic trust in the world

• Tendency to assess stressful situations in benign terms

Psychological openness may determine the degree, frequency and duration of identity exploration entered into by an individual. [Note how some CBT practitioners might have a problem with making use of psychological test results and a client’s ability to inquire into identity.] Openness is a central personality “constant” that affects ego development and identity formation (Tesch & Cameron, 1987): The relationship between openness to experience
and identity formation observed in the present study supports Rogers’s (1961) theory regarding the importance of openness for positive personality growth. … That is, openness to experience may lead to both exploration of alternative identities and to introspective and expressive behaviors, thus creating indirect associations between identity formation and various behavioral manifestations of openness to experience. . . . a tendency toward psychological openness may facilitate exploration of identity which in turn leads to greater self-awareness and openness to experience. Conversely, a person who is less open to experience may not become aware of identity alternatives, and the premature foreclosure of identity might further depress the level of openness (pp. 627-628). [Note how some CBT practitioners may prematurely foreclose identity exploration.]

Research (Griffin & Bartholomew, 1994; Shaver & Brennan, 1992) has shown that of the “Big Five” dimensions of personality (extraversion, agreeableness, neuroticism, openness to experience, and conscientiousness), openness and conscientiousness are least closely related to adult attachment. That conclusion may, indeed, reflect the dichotomy between attachment and exploration. Openness may well prove to be correlated with adult exploration [the “secure base for exploration” is a fundamental concept of secure attachment]. Secure attachment is related to higher cognitive openness (Mikulincer & Arad, 1999). For example, secure people tolerate ambiguities and contradictions well, and, showing no inherent preference for consistency, are relatively free from prior expectations in integrating new information. [Note how the stock in trade of many CBT practitioners is to point out logical inconsistencies in a client’s thinking, mislabeling that as a “cognitive distortion.”] On the contrary, ambivalent-resistant people are preoccupied with the threatening aspects of new information. Avoidant people overemphasize self-reliance, and so habitually reject any new information that might demand a revision of their beliefs.

[Note that I am labeled “avoidant” and yet I had the following exchange with my therapist that suggested her inability to deal with new information:

PATIENT: I have feelings of alienation.
THERAPIST: Let me talk about that from a different perspective. I can show you how what you’re talking about is actually fear of rejection and loneliness. . . . Other people I work with talk about fear of rejection and loneliness.

OK, but what about my feelings of intense alienation and my need for mirroring, twinship, and idealization? In fact, “feelings of alienation” and a “hunger for mirroring” are related conceptually to mainstream attachment theory! See, e.g., Shaver, P.R., Banai, B. and Mikulincer, M. “Selfobject Needs in Kohut’s Self Psychology.” (selfobject needs for mirroring, idealization, and twinship were shown experimentally to be related conceptually to attachment theory). Shaver’s paper indicated to me — probably not to Dr. Shaver, though — that Kohut’s ideas about mirroring, twinship, and idealization contain a depth, subtlety, and specificity that is lacking in the simple attachment categories of rejection and loneliness.

The therapist seemed to say, “You feel different from other people and you feel that you need people who mirror you (or that you feel alienated from people) because if they are not like you, they will reject you.” The therapist’s interpretation seemed to imply that I had feelings of shame about being different that triggered approach avoidance. That’s not what I feel. I feel frustration, not shame. I feel I need a mirror image object, and when I don’t experience that I feel alien. A coworker once made a keen observation about me: “You only like people who remind you of yourself.”

I would express my feelings in the following analogy. Say I am in China. I don’t speak Chinese. I desperately need directions to a certain location (compare, “How am I going to get home?”). I feel I need to speak with a person who speaks English to fulfill my needs; I need someone who mirrors me to fulfill my needs. I don’t fear that a Chinese person will reject me because I am ashamed that I am an “ugly American,” — I fear that he cannot fill my need that he speak English. He can think I am an ugly American all he wants. (Compare my benign response to Dr. Palombo’s criticisms: “You are a freak.” “You are a buffoon.” I couldn’t care less about those statements.) I see my mirroring needs as fundamentally rooted in a need to cure a narcissistic defect in the self — not in a healthy anaclitic need for
kinship with another. I am not looking for a Chinese friend, rather, I have a narcissistic need to use him — or exploit him — to cure a defect in myself. I don’t see attachment theory addressing that specific need. In the therapy situation, I need a therapist who “speaks English.” I don’t need to be loved and comforted by a therapist. I am not looking for a friend.

What I experience consciously is not the need for a friend but a “selfobject” — a need for affirmation, validation, and mirroring from an important, or idealized other, who offers himself for identification for the purpose of enhancing growth. The conscious feeling I experience is not loneliness but “selfobject hunger.” By analogy, when a person with hypoglycemia asks for a glass of orange juice — it is not to satisfy his alimentary needs (thirst), but to cure a defect in the self. Can attachment theory explain this need?

A paraphrase from a paper on anorexia nervosa — perhaps, significantly, a paper on anorexia nervosa! -- provides an exquisite description of my struggle with the problem of idealization:

_The only Other that matters for me is the Other of the reflected mirror image, the Imaginary Other, the idealized similar one, the Other as an ideal projection of my own personality elevated to the dignity of an icon, the Other as a reflected embodiment of the Ideal Ego, as a narcissistic double of the subject, the idealized Other of the reflected image of the self._ Recalcati, M. “Separation And Refusal: Some Considerations On The Anorexic Choice.”

Dr. Shaver writes that Kohut’s ideas about the origins of selfobject hunger relate to specific attachment anxieties: “When parents fail to satisfy selfobject needs by providing mirroring and opportunities for idealization and twinship, the transmuting internalization process is disrupted and pathological narcissism may appear. The sense of self-cohesion will not develop, and powerful archaic needs for admiration, powerful others, and twinship experiences will remain. In Kohut’s words, “the psyche continues to cling to a vaguely delimited image of absolute perfection.” That is, the person retains a chronic, archaic “hunger” for selfobject experiences, and his or her behavior is characterized by a continuing search for satisfaction of unmet selfobject needs. . . .
Kohut’s broad ideas about hunger for selfobject provisions and avoidance of selfobject needs in adulthood as reactions to the deprivation of selfobject provisions during childhood resemble Fraley and Shaver’s hypothesis about two different psychological reactions to deprivation of attachment provisions.” “‘Selfobject’ Needs in Kohut’s Self Psychology: Links With Attachment, Self-Cohesion, Affect Regulation, and Adjustment.”

NOTE WELL: Dr. Shaver writes elsewhere the following observations that might possibly relate to Self-Selfobject relationships. Is there a possibility that such “couplings” are not even attachment-based?

“[Revised attachment theory] should no longer include the implicit assumption that all romantic, or couple, relationships are attachment relationships. Although the original theory did not explicitly claim that all coupled partners were attached in the technical sense, Hazan and Shaver did not really address the possibility that some partners were attached and some were not, nor did they offer a method for making this distinction empirically. Over the last few years, researchers have tackled the problem and provided preliminary but useful methods that should be included in future studies.”

Do Dr. Shaver’s observations contemplate the possibility that “selfobject hunger” is not attachment based – analogous to the fact that a hypoglycemic's need for glucose is not alimentary based -- and that my desires for connection with an idealized other have nothing to do with loneliness and a desire for a friend?

Dr. Shaver writes, significantly: "Each theory has boundaries and attachment theory is no exception. In fairness to Bowlby, he was not attempting to explain every aspect of or type of close relationship. His aim was simply to explain the structure and functions of attachment . . . ." Shaver, P.R. "Attachment as an Organizational Framework for Research on Close Relationships."

Is it a misreading of Dr. Shaver to say that perhaps not all relationships – perhaps even emotionally significant relationships (such as that between a
narcissist and an idealized Other) – constitute an "attachment" in a technical sense?"
THERAPY SESSION: JUNE 6, 2018

At the outset of the session I said to the therapist, "I had the feeling last time that you were feeling overwhelmed by me. My sense that you felt overwhelmed was triggered by your statement at that session: 'You think you’re smarter than everybody else.'"

I had the subjective impression that the things I discussed at that earlier session had threatened the therapist and that her response at this session to my comment that she seemed to have been “overwhelmed” was defensive. Concerning my recollection that she had said a week earlier “You think you’re smarter than everybody else,” she said: “That’s not something I would have said.” Concerning my statement at this session that she seemed to have been overwhelmed the previous week, she said: "A person can't read minds." "I wasn't feeling overwhelmed." "Let's look at how your impressions of other people came into play in your workplace relationships.” I began to experience discomfort with the therapist's persistence and at one point I said, “I don't want to spend the entire hour talking about this.”

Was there a more productive approach the therapist could have taken? Perhaps she could have asked: “Were there times in your relationship with your mother that you felt you overwhelmed her emotionally?” “Did you feel emotionally constricted in your relationship with your mother to the point that you felt you needed to suppress your feelings around her?” “Did you feel that if you aroused negative emotions in your mother she would punish or reject you?”

In fact, it's been recognized that a particular parenting style promotes a dismissive avoidant attachment style in children, that is, a type of attachment style in which the individual scorns relationships and relies instead on pathological self-sufficiency: “Parents of children with an avoidant attachment tend to be emotionally unavailable or unresponsive to them a good deal of the time. They disregard or ignore their children’s needs, and can be especially rejecting when their child is hurt or sick. These parents also discourage crying and encourage premature independence in their children.
In response, the avoidant attached child learns early in life to suppress the natural desire to seek out a parent for comfort when frightened, distressed, or in pain. Attachment researcher Jude Cassidy describes how these children cope: “During many frustrating and painful interactions with rejecting attachment figures, they have learned that acknowledging and displaying distress leads to rejection or punishment.” By not crying or outwardly expressing their feelings, they are often able to partially gratify at least one of their attachment needs, that of remaining physically close to a parent.

Children identified as having an avoidant attachment with a parent tend to disconnect from their bodily needs. Some of these children learn to rely heavily on self-soothing, self-nurturing behaviors. They develop a pseudo-independent orientation to life and maintain the illusion that they can take complete care of themselves. As a result, they have little desire or motivation to seek out other people for help or support.”

Is my act of writing letters about my therapy sessions, in part, a form of self-soothing or self-nurturing that I turn to because I feel I cannot share my feelings and perceptions with my therapist? Does this therapist permit me to have negative feelings about her? At a deep, unconscious level does the therapist interpret my negative comments about her as the symbolic biting behavior of the infant feeding at his mother’s breast?

POSSIBLE THERAPIST ANXIETY IN RELATION TO ME

It is recognized that difficult or triggering clients can arouse anxiety in a therapist. Shamoon, Z.A., Lappan, S., Blow, A.J. “Managing Anxiety: A Therapist Common Factor.” Contemporary Family Therapy, 39(1): 43-53; (March 2017). The authors propose that effective therapists need to be able to manage their emotions, especially their anxiety, in order to truly help their clients. The failure to do this can lead to break downs in the alliance and the flow of therapy, and these deleterious effects can be prevented when therapists actively navigate their internal states through self-awareness and ongoing introspection.

Were there signs of anxiety in the therapist's response to me?
The therapist seemed to deny having said at the previous session, “You think you're smarter than everybody else.” She said, “That's not something I would say.” But was there in fact a discrepancy between what the therapist said she felt and what she actually felt? Can a client be sensitive to such discrepancies in a therapist?

Interestingly, several sessions ago, the therapist said in another context, “Are you always right?”

Let's look at those two statements:

“You think you're smarter than everybody else.”

“Are you always right?”

Notably, both statements are black and white statements or “all or nothing” statements, suggestive of splitting. It is recognized that individuals can regress to a state of splitting in response to anxiety, that is, in response to feelings of being threatened. Anxiety causes individuals to revert to paranoid-schizoid thinking which defends the self by the dichotomous splitting of ideas into good and bad (or all or nothing), 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.” Hirschhorn, L. The Workplace Within: Psychodynamics of Organizational Life.

I am reminded of an interaction I had in therapy in about July 1994, when I was in treatment with Dimitrios Georgopoulos, M.D. Dr. Georgopoulos responded angrily after I seemed to contradict him by saying, “You’re changing the focus.” He said, “Everybody has to agree with you? Nobody can disagree with you?” The therapist responded with what appeared to be “all or nothing” thinking.
Is it possible that my resistance in therapy triggers anxiety in the therapist, which arouses a paranoid response, namely, a regression to “all or nothing” thinking? Does my failure in group situations, such as the workplace, to relinquish my individual identity and assume a group identity trigger retaliatory aggression by group members? I don't know. It's only a tentative idea.

**IS IT POSSIBLE FOR A THERAPY CLIENT TO READ MINDS?**

The simple answer is no. We cannot read another person's mind. But several caveats need to be stated.

Some clients are recognized to be psychologically minded. Psychological mindedness refers to a person's capacity for self-examination, self-reflection, introspection and personal insight. It includes an ability to recognize meanings that underlie overt words and actions, to appreciate emotional nuance and complexity, to recognize the links between past and present, and insight into one's own and others' motives and intentions. Psychologically minded people have above average insight into mental life.

Some definitions of psychological mindedness relate solely to the self, "a person's ability to see relationships among thoughts, feelings, and actions with the goal of learning the meanings and causes of his experiences and behaviors.” The concept has been expanded beyond self-focus, as involving "... both self-understanding and an interest in the motivation and behavior of others".

The writings of Harold Searles, M.D. have centered on the honesty required of a therapist to acknowledge the patient's insights about the therapist’s internal mental states. Searles, who happened to be one of the most eminent psychiatrists of the twentieth century, wrote that he has very regularly been able to find some real basis in himself for those qualities which his patients – all his patients, whether the individual patient be more prominently paranoid, or obsessive-compulsive, or hysterical, and so on – project upon him. It appears that all patients, not merely those with chiefly paranoid adjustments, have the ability to "read the unconscious" of the therapist. This process
of reading the unconscious of another person is based, after all, upon nothing more occult that an alertness to minor variations in the other person's posture, facial expression, vocal tone, and so on, of which the other person himself is unaware. All neurotic and psychotic patients, because of their need to adapt themselves to the feelings of the other person, have had to learn as children - usually in association with painfully unpredictable parents – to be alert to such nuances of behavior on the part of the other person.

Albert Rothenberg, M.D. found that some patients were unusually sensitive to the implicit messages contained in others’ communications, a sensitivity that resulted from these patients’ adaptation to a disturbed developmental environment in which there were often remarkable discrepancies between what family members said they felt and what they actually felt. Rothenberg, A. Creativity and Madness at 12 (Baltimore: The Johns Hopkins University Press, 1990).

Park and Imboden found that some clients have 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 some clients have a cognitive giftedness in the area of self- and other-perceptiveness called “personal intelligence.” The authors recommended validating, when appropriate, the following characteristics of such clients: exceptional personal intelligence; and the absolute right to experience their innate capacity for freely enjoying their feelings, their perceptions, and thoughts (including thoughts about the therapist). Park, L.C. and Imboden, J.B., et al. “Giftedness and psychological abuse in borderline personality disorder: Their relevance to genesis and treatment.”

Is there any basis to this therapist's assertion that I could not possibly have accurately read her internal mental state of anxiety and perceived threat? Probably not. Indeed, according to Searles and Rothenberg, a patient who grew up in an disturbed family environment with “painfully unpredictable parents” is exactly the type of client who would be most likely be able to read
a therapist's internal mental states. When a therapist denies a gifted client's intuitive abilities, is she not, in fact, invalidating the client – an action that is anti-therapeutic?

**DOES THE THERAPIST ENGAGE IN PREMATURE CLOSURE?**

"Premature closure is a maladaptive, pre- and unconscious, inappropriate defensive maneuver that a counselor may use when overwhelmed by the professional challenge. Expressions of premature closure can be an inability to handle the client’s intense emotions or an inability to enter or stay in the experiential world of the client." Skovholt, T.M. and Rønnestad, M.H. “Struggles of the Novice Counselor.” *Journal of Career Development*, 30(1): 45-58 (2003).

At my first session with this therapist I reported that I believed my mother was a negligent mother. *That was my experiential world.* Instead of delving into my perception of maternal negligence, the therapist chimed in at once, "I wouldn't say your mother was negligent." How would the therapist be able to offer an opinion on that issue after knowing me for only a half hour?

At this session I stated the following: “I have been thinking about something relating to my maternal grandfather – my grandmother's husband. He died in the great flu epidemic of 1918, when my mother was three years old. I'm attracted to the tentative idea that he might have been an exploitive person. He was originally from Poland but had lived in the United States for a period. Then he went back to Poland, apparently to look for a wife. They got married and moved together to the United States in 1910. She left her entire family behind and never saw them again. My grandmother was 18 years old. And, you know, I'm thinking, he might have exploited my grandmother. Maybe he sold my grandmother a bill of goods about how wonderful America was and what a wonderful life they would have together in the United States. Maybe he took advantage of her. (If this were so, the relationship would uncannily parallel the relationship between my sister and her late husband, who was an unusually interpersonally exploitive person, an individual who convinced my sister that he was “a perfect person who had no flaws” and that he was the child of a “perfect mother.”)
The idea that my maternal grandfather was an interpersonally exploitive individual is a tantalizing one because that view of him is consistent with a narcissistic family dynamic that may have been transmitted through the generations. See, e.g., Beatson, J.A. “Long-term psychotherapy in borderline and narcissistic disorders: when is it necessary?” Aust N Z J Psychiatry., 29(4):591-7 (Dec. 1995) (Patients with borderline and narcissistic pathology who have sustained severe early developmental trauma will often require long-term psychotherapeutic treatment to achieve lasting psychological change. Such treatment is necessary for the relief of suffering in the patients, and may contribute to the alleviation or prevention of the intergenerational transmission of these disorders).

At once the therapist responded to my narrative, “I wouldn't say he was exploitive. Maybe he was just an optimist. Maybe he filled your grandmother with optimistic ideas about a better life in America.”

My subjective impression of the therapist is that she has a persistent “Pollyanna” quality that forces her to turn away from the darker edges of my experiences and emotional problems, to wit, “Your mother wasn't negligent.” "Your grandfather wasn't exploitive." "You can make friends if you try; you simply need to take risks with people."

Note the possible projective aspect of the therapist’s statement, “Maybe he was just an optimist. Maybe he filled your grandmother with optimistic ideas about a better life in America.” Is the therapist herself an optimistic individual who is trying to get me to internalize her overly-optimistic view of my reality as well as get me to turn away from delving into the darker side of my experiential world? One wonders.

The fact is that in attachment theory, the best evidence for the actual relationship between the patient and his attachment figures – such as a negligent mother or an exploitive grandfather – is the client's unconscious internal working model, that is, the unconscious internal schema of interpersonal expectations and fears that an individual forms in response to his lived experience with early attachment figures. According to theory, the unconscious internal working model is a kind of "black box (or flight data recorder)" of the actual lived relationship between the patient and his early
attachment figures in contrast to the conscious internal working model that may be based on defensive distortions. The unconscious internal working model is the "best evidence" of the nature of the relationship between the client and his early attachment figures, according to theory. The therapist's idle, optimistic speculation about my attachment figures is as meaningless as saying – before analysis of the black box evidence in an airplane crash investigation — "well, maybe the pilot wasn't negligent, maybe he did everything he was supposed to do." Those are just empty words. It's what an analysis of the black box data tells you that is definitive; notions that are simply need-satisfying to the airline (or therapist) have no value.

"Bowlby writes that 'the particular form that a person's working models take are a fair reflection of the types of experience he has had in his relationships with attachment figures.' This is a straightforward claim that working model representations constitute a relatively accurate reflection of actual events. However, Bowlby also allows 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 a distorted product of defense." Eagle, M.N. Attachment and Psychoanalysis Theory, Research, and Clinical Implications.

In light of attachment theory, does it make sense for a therapist to simply speculate that the client's mother was not negligent without the therapist having a depth understanding of the client's unconscious internal working model, which will have encrypted the lived relationship between the client and his mother, including mother's possible inadequacies? Does it make sense for a therapist to simply speculate that the client's grandfather was not an exploitive individual without the therapist having a depth understanding of the client's unconscious internal working model, which may have encrypted the issues of intergenerational transmission of narcissistic or exploitive family dynamics? See, e.g., Beatson, J.A. “Long-term psychotherapy in borderline and narcissistic disorders: when is it necessary?” Aust N Z J Psychiatry., 29(4):591-7 (Dec. 1995) (borderline and narcissistic disorders are transmitted intergenerationally).
John Bowlby, M.D. himself – the father of attachment theory – strongly emphasized the importance of the therapist in helping the patient to recognize and accept the dark side of his experiences. Bowlby said: “So there is a reason why I think it's – the greatest reason to assist a patient discover their own past and also, of course, to realize, to recognize, how it comes about how they cannot initially come to, can't do it, or don't want to do it. Either it's too painful – no one wants to think that our mother never wanted them, and always really rejected them, it's a very painful, very, very painful situation for anyone to find themselves in. Yet if it's true, it's true, and they are going to be better off in the future if they recognize that that is what did happen.”


What is a therapist's hidden agenda in offering mere speculations that seem to consistently rationalize the possible empathic failures of the client's attachment figures? In trauma work, isn't the pertinent issue the nature of the client's psychological injury – which speaks for itself – and not mere speculation about historical facts relating to the source of the injury? Analogy: a driver was in a bad car accident, was severely injured, and has been taken to the emergency room. The patient's injury (trauma) speaks for itself. Does it make sense for the emergency room doctor to speculate about whether the other driver was negligent; whether the other driver was an exploitive individual who didn't care if he drove while intoxicated? Aren't these questions, in fact, moral issues that are irrelevant to the trauma? Does trauma, at least as it relates to the survivor, even have a moral dimension? In working with a client who has serious character pathology aren't the following questions the only pertinent questions from an attachment theory perspective: Does this client show the recognized consequences of maternal negligence? Does this client show the recognized consequences of an exploitive family, including possible intergenerational transmission of narcissistic family dynamics? Again: What is a therapist's hidden agenda in offering mere speculation that seems to consistently rationalize the possible empathic failures of the client's attachment figures? Why would such reassuring speculations be need satisfying to a therapist? Why would a therapist who claims to be an attachment therapist deny the clear implications of possible evidence of the client's unconscious internal working model?
INTUITIVE GIFTEDNESS AND THE NARCISSISTIC NEED FOR TWINSHIP, IDEALIZATION AND MIRRORING: “A young man whom the superiors had their eyes on . . .”

At another point in the session I related the following: “You were talking about my need to take risks with people and I want to talk about that. This also relates to the issue of intuition. I don’t like most people. I wouldn’t be interested in most people for friends. I mean there are people I chat with in my apartment building and sometimes I wish I didn’t. I talk to most people out of politeness. I’m not really interested in talking to them or being their friend. If you talk to some people they get the idea that they want to be your regular chat buddy, and I hate that. I don’t like having to chat with people I would prefer not chatting with.

So, anyway, this goes back 15 years to the year 2003. There was a new guy in my building. His name was Brad Dolinsky. I didn’t know anything about him. But I was curious about him. He wore Army fatigues sometimes. [My father had served in the U.S. Army in World War II and spoke often about his military experiences.] Once he gave some cookies to the guy at the front desk. In my mind, I thought of him as “the cookie guy.” He was somebody I would be interested in talking to. I asked the front desk manager who he was. She said, “That’s Brad Dolinsky. He’s a doctor. He’s doing his residency at Walter Reed. He’s very smart. There are people high up in his field who have their eye on him.” I thought, “I knew it! I could tell there was something different about that guy.”

So I researched the guy on the Internet. And I learned that there were several technical papers that he had co-authored – and he was still only a resident. This confirmed for me that I can read people.

I told my therapist (Dr. Israella Bash) about him. Dr. Bash was always saying I should make friends. I told Dr. Bash that Brad Dolinsky was somebody who could be a friend for me. When I told her he was a medical doctor, she said, “Put that out of your mind. No medical doctor would be friends with you. You need to be friends with people at your level (and she didn’t mean that in a good way!).” He’s about 25 years younger than me.
So about taking risks. We used to have a roof deck in my building. It’s closed now. Brad Dolinsky used to sunbathe on the roof. I always thought that was odd, that a medical doctor would sunbathe. And sometimes he would get red as a lobster. Anyway, one day he came up to the roof and laid down on a lounge chair. He was right across from me. I was thinking of introducing myself. But I didn’t have the nerve. So I could have introduced myself, and maybe we would have chatted. And maybe when he saw me he would have waved to me and said, Hi. But that would have been it. We would never have become friends. He lives in Washington State now. He’s married and has a couple of kids.”

*Was my unusual reaction to Brad Dolinsky an outcome of my possible intuitive giftedness, an uncanny skill that enables me to sense another individual's ability to gratify my need for self-sameness – that is, gratify my need for narcissistic mirroring?*

*The following observation in the above narrative is significant: “There are people high up in his field who have their eye on him.”*

**Related Anecdotes:**

In the fall of 1973 I took an introductory course in meteorology at Penn State. It was my junior year. The class was a large lecture-hall type class. Joel Myers, Ph.D., President of AccuWeather, was the instructor. Myers is a nationally-prominent meteorologist. He served on the faculty of Penn State from 1964 until 1981 as instructor, lecturer and assistant professor and has taught weather forecasting to approximately 17% of all practicing meteorologists in the United States upon retirement from active teaching in 1981.

The meteorology course I took had a lab component, where students broke up into small groups.

One day Myers asked a question in class. I appeared to be the only student in the lecture hall to raise his hand. I gave the correct answer.

Weeks passed.
One day I was walking through the hall in the Earth Sciences building where Myers’ office was located. Myers saw me. As I approached, he said, “Hello, Gary.” How did he know my name? Why would he know my name?

My only thought is that my answer to his question in class weeks earlier had triggered his curiosity, and he asked the lab instructor who I was.

People take notice: “There are people high up in his field who have their eye on him.”

Following my graduation from college I got a job as an editorial assistant at The Franklin Institute in Philadelphia.

In March 1976, when I was 22 years old, the Vice President of the Franklin Institute (Alec Peters) sent a note to my supervisor (Bruce H. Kleinstein, Ph.D., J.D.) saying that he should put “an annotation” in my personnel file stating that I was doing a good job. I had absolutely nothing to do with Alec Peters! Why did he do that? Why did the Vice-President of the Franklin Institute take an interest in me?

“There are people high up in his field who have their eye on him.”

My autobiographical book Significant Moments includes the following pertinent passage:

Joseph himself would scarcely have imagined that . . .

Hermann Hesse, Magister Ludi: The Glass Bead Game.

. . . his precocious . . .

Charles Dickens, Dombey and Son.

. . . appointment to Mariahels represented a special distinction and .

. . .

Hermann Hesse, Magister Ludi: The Glass Bead Game.

. . . one of the major steps in a candidate’s progress . . .


. . . but he was after all a good deal wiser about such matters nowadays and could plainly read the significance of his summons in
the attitude and conduct of his fellow students. Of course, he had belonged for some time to the innermost circle within the elite of the Glass Bead Game players, but now the unusual assignment marked him to all and sundry as a young man whom the superiors had their eyes on and whom they intended to employ.


What is the significance of an interplay between my possible intuitive giftedness and my narcissistic need for twinship, idealization and mirroring? Is there an interplay between my sense of alienation from others who do not mirror me and my uncanny ability to sense certain persons' shared self-sameness?
THE DREAM OF SCHUBERT'S FINAL PIANO SONATA

Schubert wrote the Piano Sonata in B flat major in the last year of his life, when he probably knew he was dying. It is a long work – longer than any piano sonata by Mozart and Haydn – and it shows much influence of Beethoven. It was his final piano sonata. I read that Schubert died a few days after he completed the piece; he was 31 years old. About a year ago I downloaded a recording of the sonata on my iPod, a version performed by the great Chilean pianist Claudio Arrau. I had seen Arrau perform the Brahms First Piano Concerto in person at the Robin Hood Dell (in a program that included the Beethoven Seventh Symphony) in the summer of about the year 1972, when I was 18 years old.

Dream of Schubert’s Final Piano Sonata

On the evening of May 21, 2018 I had the following dream:

I am watching the movie Dr. Zhivago on television. I am experiencing feelings of confusion because the movie seems to include scenes I have never seen before. I think: “How can this be? I have seen this movie so many times; how can it be that I can’t remember these scenes? Did I forget seeing these scenes, or is this a different version of the movie?” I keep hearing Schubert’s final piano sonata. I am entranced by the music. I am overcome with feelings of wistfulness and nostalgia — commingled with the aforementioned feelings of confusion.

The following are simply associations. These associations do not constitute an interpretation of meaning.

1– In the hours before the dream, I wrote a blog post about my impoverished sense of identity. I have the sense that I have no access to my feelings and important mental states, and can only talk about analogous things I read about with which I identify. It’s as if the texts I read and identify with are a mirror reflection of my inner mental states: photographic images of my inner self.
On Mirrors and Intellectualization

Imagine the following fanciful image:

A man is invisible to himself. He cannot see himself. When he turns his head down toward his body he sees nothing. People say to him: “Describe your appearance. What do you think you look like?” He answers: “I have no idea what I look like. I have never seen myself. I am invisible.” One day he passes by a mirror and sees his reflection for the first time. He gets an idea of what he looks like. Now when people say, “Talk about your physical appearance,” he describes the reflected image he saw in the mirror. He still can’t see himself. He can only describe the reflected image.

Psychologically I am invisible to myself. I can’t talk about my feelings. I can talk about my thoughts and notions I have about myself, but I can’t talk about how I feel or what motivates my behavior. I read things that I identify with — novels, biographies, history, any text. I talk about these texts with my therapists. They say I intellectualize. I need to talk in my own words and describe my feelings. But I am invisible to myself. I can only see my reflected image in the texts that I read with which I identify. I read about Freud and I can talk about aspects of Freud that I identify with. Some therapists think I am grandiose: that I am trying to show off. “He reads these psychoanalytic journals and tries to impress me with his brilliance.”

My behavior is narcissistic — but not grandiose. It’s as if I am narcissistic in a Kohut sense but not in a Kernberg sense. I have a profound lack of self, a profound lack of self awareness. My only access to myself is in my readings and what I identify with.

I used to bring books to Dr. Palombo all the time and read passages to him. If he had been a Kohutian he might have had an insight: “It’s as if this patient is bringing his own mirror into the consult with him. He is presenting me week after week with his reflected image in the mirror. But his real self is obscure to him.”

The text of the blog post is as follows:

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I wonder if this is a trauma issue. Is this an expression of dissociation —

dissociation rooted in trauma or abuse?

2– In the past few days I had been thinking of my law professor, Claudio

Grossman, an individual I admired a great deal and with whom I identified.

Grossman was originally from Chile, like the pianist Claudio Arrau. A few
days ago I wrote a blog post about Grossman’s complex background, and
issues of his personal identity. Grossman was an immigrant, someone who
had left his homeland.

3– In high school I had a French teacher named Linda Schubert Miller. She

got married in the spring of 1968, when I was in the ninth grade and I always
thought of her as “Miss Schubert.” A few days ago I posted an image of
Miller from a 1969 high school yearbook on my sister’s Facebook page. I
asked my sister, “Does it look like her?” My sister replied, “Yes, it does.”
About 10 years ago, my sister and Miller were neighbors in Cherry Hill, NJ.
My sister knew Miller. Miller’s husband was a musician.

4– In May 1980 I lived in Spokane, Washington, attending my first year of

law school. On Sunday morning of May 18, 1980 Mt. St. Helens erupted in
Washington, State. Spokane was downwind from the volcanic ash and an
emergency situation arose in Spokane. I wasn’t listening to the radio that
morning and I knew nothing about the eruption. I took a leisurely walk
downtown that afternoon. I saw a huge, grayish-green cloud slowly moving
toward the city. I thought, “Wow, I never saw anything like that before!
That’s amazing!” The movie, Dr. Zhivago was playing at a theater
downtown and I decided to see it — for perhaps the seventh time in my life.
That was a misadventure. When I got out of the theater, Spokane was
engulfed in the volcanic ash — microscopic particles that created a dense
haze. There was extremely limited visibility. It was worse than a blizzard or
a bad fog. I walked down the street. I thought: How am I going to get home?
(Think of that as a metaphor: “How am I going to get home?”) An
anonymous driver was kind enough to pick me up and drive me home. At the
present moment, the state of Hawaii is coping with a volcano emergency.
My mother died in January 1980. Psychoanalytically, perhaps a volcano is
symbolic of an orgasm. According to Freud and others sex is the polar opposite of death.

5– In the year 2012 I had a dream about Laurence C. Sack, M.D., a psychiatrist I saw in consultation in 1991. I admired Dr. Sack a great deal. He was a brilliant man. The dream seemed to concern wistful feelings about Dr. Sack’s lost youth and his growing old. The manifest dream related to Sack’s status as an immigrant: someone who left his homeland. The dream seemed to be triggered by a photograph I had seen earlier in the day of the composer, Johannes Brahms.

6– My grandmother died in September 1972, when I was 18 years old. In about the year 2007 I saw an episode of the TV show Six Feet Under. A young man asks a young female photographer friend to take his photograph nude. She mentions that she is 18 years old and he replies: “What you don’t know when you’re 18 is that you’ll be 18 for the rest of your life.” I think of that line often. “What you don’t know when you’re 18 is that you’ll be 18 for the rest of your life.” Incidentally, my grandmother emigrated from Poland to the United States in 1910 at age 18. My grandmother was an immigrant who left her homeland. Were there times when my grandmother wanted to return home? Did she think: “How am I going to get home?”

I lost my grandmother when I was 18, the same age my grandmother was when she lost her entire family in 1910.

There is a line from the opening of the movie Dr. Zhivago. Zhivago’s half-brother Evgraf is talking to Zhivago’s daughter.

You see...
...he lost his mother...
...at about the same age you were...
...when your mother lost you.
And, in the same part of the world.

Attachment theory research raises tantalizing questions about the significance of my mother’s loss of her father at age 3 (in the great flu epidemic of 1918)
– leaving my mother, her two year older sister (age 5), and mother (my grandmother, age 26) in dire poverty – as well as my grandmother's loss of her entire family, earlier, in 1910, at age 18, upon emigrating to the United States.

Research findings indicate that loss can undergo intergenerational transmission. “[There is] preliminary evidence that a mother’s own attachment experience in childhood may influence the development of reward and affiliation circuits in the brain that promote contingent and sensitive responses to her own infant’s cues. That is, a mother’s attachment experiences from her own childhood may shape neural circuits which influence how she perceives and responds to her infant’s cues one generation later.” Shah, P.E.; Fonagy, P.; and Strathearn, L. “Is Attachment Transmitted Across Generations? The Plot Thickens, Clin Child Psychol Psychiatry, 2010 Jul; 15(3): 329–345 (July 2010).

Additional attachment-theory models indicate the possibility that transmission of specific traumatic ideas across generations may be mediated by a vulnerability to dissociative states established in the infant by frightened or frightening caregiving, which, in its turn, is trauma-related. Disorganized attachment behavior in infancy may indicate an absence of self-organization, or a dissociative core self. This leaves the child susceptible to the internalization of sets of trauma-related ideation from the attachment figure, which remain unintegrated in the self-structure and cannot be reflected on or thought about. The disturbing effect of these ideas may be relatively easily addressed by a psychotherapeutic treatment approach that emphasizes the importance of mentalization and the role of playful engagement with feelings and beliefs rather than a classical insight-oriented, interpretive approach. Fonagy, P. “The transgenerational transmission of holocaust trauma.” Attachment & Human Development, 1(1): 92-114 (April 1999).

The fictional dialogue between the characters Billy and Claire on the TV drama Six Feet Under is significant:

BILLY: Come on in. All right, let me show you. [Billy shows Claire the camera on a tripod.] You can put your purse down if you like. Here it is.
This is your focus, and this is your zoom. That’s pretty much it. So here you go. You’ll get a feel for it.

CLAIRE: Okay, what do you want me to do?

BILLY [pulls off his robe with his naked back to Claire]: Just, you know, follow your instincts. Relax. Don’t think about yourself at all. I know that’s impossible for a 17-year-old.

CLAIRE: Eighteen.

BILLY [his back to Claire:] What you don’t know is you’re going to be 18 for the rest of your life. I’ve tried to do self-portraits before but they always turn out so contrived, like I’m trying to be some version of myself. So f----g juvenile. And I really want to see it, you know? [referring to the scar on his back.] I want to. I need to see what I’ve done. And I think it really is impossible for somebody to see themselves. You need someone else’s eyes. I need somebody else to see me. Somebody who isn’t Brenda [Billy’s sister]. She sees things a little too darkly. I mean, I don’t need any help going there. Besides, I’ve looked through her eyes enough for one lifetime, you know. What are you seeing?

CLAIRE: I’m on your scar, really close up. [Billy has a scar on his back from a wound he inflicted on himself during a psychotic manic attack.]

BILLY: What does it look like?

CLAIRE: Like the surface of the moon.

BILLY: That’s good. That’s the thing about Narcissus. It’s not that he’s so f----g in love with himself, because he isn’t at all. F----g hates himself. It’s that without that reflection looking back at him he doesn’t exist. [Billy starts to cry]

CLAIRE: Billy, are you okay?
BILLY: Yeah. Don’t be freaked out. This is good. This is exactly what I needed to happen. I’m f----g crying. Oh, God, I’m sorry, this is intense. [Billy turns around, exposing himself to Claire. She is extremely embarrassed. She averts her gaze and walks out.]

BILLY: You can go.

Think of the line, “It’s that without that reflection looking back at him he doesn’t exist.” May we paraphrase and say, “It's that without my books (my reflected image), I don't exist?”

7– Excerpt from my book Significant Moments (May 22, today, is Wagner’s birthday):

Three nights before his death, . . .

**Martin Gregor-Dellin, Richard Wagner: His Life, His Work, His Century.**

Almost poetically, . . .

**Peter Gay, Freud: A Life for Our Time.**

. . . he dreamed of meeting . . .

**Martin Gregor-Dellin, Richard Wagner: His Life, His Work, His Century.**

. . . his mother . . .

**Richard Wagner, Parsifal.**

. . . looking young and attractive and altogether unlike his early recollections of her.

**Martin Gregor-Dellin, Richard Wagner: His Life, His Work, His Century.**

Yet again the occasion for the dream was a real event. The day before . . .

**Sigmund Freud, The Interpretation of Dreams.**

. . . he had received . . .

**Charles Dickens, The Old Curiosity Shop.**

. . . a photograph of his mother as a young woman. He looked at it, long and closely, remarking in a scarcely audible tone: “Fantastic!” Was this the bond of trust and the sense of “I” connecting mother and newborn,
old man and “Ultimate Other”? 


8– The musical score for the movie *Dr. Zhivago* was written by Maurice Jarre, a French composer. I loved that music!

9– Both the book and the movie *Dr. Zhivago* open with the funeral of the boy Zhivago’s mother:

*On they went, singing ‘Eternal Memory’, and whenever they stopped, the sound of their feet, the horses and the gusts of wind seemed to carry on their singing.*

*Passers-by made way for the procession, counted the wreaths and crossed themselves. Some joined in out of curiosity and asked: ‘Who is being buried? – ‘Zhivago,’ they were told."

‘Oh, I see. That explains it.’ – ‘It isn’t him. It’s his wife.’ – ‘Well, it comes to the same thing. May she rest in peace. It’s a fine funeral.’
GARY FREEDMAN

Re-interpretation of psychological test raw data.

On the MMPI a T-score of 65 or higher is considered statistically significant.

1. High schizoid score on the MMPI (T Score of 85) (possible inference: unempathic mother). The patient shows a lack of social interest; he is socially detached, with a rich, elaborate, and internal fantasy world.

Patient's high schizoid score (T Score of 85) is consistent with social anhedonia, a genuinely asocial trait and not a defensive reaction to social isolation. People high in social anhedonia were more likely to be alone and to prefer solitude. When alone, socially anhedonic people did not attribute their solitude to perceived or expected social rejection; instead, they reported being alone by choice. When with other people, socially anhedonic people reported asocial feelings and took part in larger and less intimate social groups. Finally, social anhedonia moderated the effect of solitude on positive and negative affect: people high in social anhedonia reported more positive affect and less negative affect when they were alone than when they were with other people. Kwapil, T.R. “The Social World of the Socially Anhedonic: Exploring the Daily Ecology of Asociality.” Journal of Research in Personality 43: 103-106 (2009).

2. High narcissistic score on the MMPI (T score of 105) (possible inference: mother who failed to mirror child or who used patient to satisfy her own psychological needs). Patient may have an extravagant need for twinship, idealization, and mirroring (Kohut). A speculative inference is warranted. Idealization can be a manic defense against loss (Akhtar); there is a remote possibility the patient is struggling with pathological mourning (see paragraph 4, below). Kieffer identified an “entitled victim” syndrome characterized by significant schizoid traits
(T=85) and narcissistic traits (T=105) combined with unconscious mourning (melancholia) (T=76) and a hunger for an idealizing relationship. Kieffer, C. “Restitutive Selfobject Function in the ‘Entitled Victim:’ A Relational Self-Psychological Perspective.”


4. Patient is depressive (T score of 76).

5. Patient experienced abuse and scapegoating in family of origin (MMPI Family Discord scale, T=65). The MMPI social alienation score of T=71 supports an inference of scapegoating in the family of origin. Gordon, R.M. “Definitions of MMPI/MMPI-2: Basic Scales and Subscales.” The PTSD scale was mildly elevated (T=60), though not statistically significant. However, it is not clear whether the MMPI can detect disguised presentation of complex trauma (Galinas). Note that characterological depression (T=72) is a characteristic feature of disguised presentation of complex trauma (Galinas). Patient views relationships as dangerous (MMPI Code type: 4–6) and has a wounded sense of self (MMPI Code type: 4–6), which are characteristics of complex trauma. Tarocchi, A. “Therapeutic Assessment of Complex Trauma: A Single-Case Time-Series Study.” Clin Case Stud. 12(3): 228–245 (June 2013). The patient’s MMPI Code type 4-6 is consistent with abusive parenting: 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. Marks, P.A., Seeman, W., and Haller, D.L. The actuarial use of the MMPI with adolescents and adults. Baltimore: Williams & Wilkins (1974).
A sense of entitlement can grow out of an abusive family environment. Kramer, S. “A contribution to the concept ‘the exception’ as a developmental phenomenon.” Child Abuse Negl. 11(3):367-70 (1987). (See paragraph 2, above: Kieffer has identified an “entitled victim” syndrome that combines schizoid traits (T=85), narcissistic traits (T=105), and unconscious mourning (melancholia) (T=76) with a hunger for an idealizing relationship.). See also, “Mediating Role of Maladaptive Schemas between Childhood Emotional Maltreatment and Psychological Distress among College Students, Practice in Clinical Psychology, 3(3): 203-211 (2015) (emotional maltreatment in childhood is etiologic for adult feelings of defectiveness/ shame, vulnerability to harm, self-sacrifice, and entitlement).

a) Patient may experience anxiety and guilt in relation to drive expression, typical of individuals who were subjected to scapegoating and massive projections in the family of origin (Family Discord, T=65; Social Alienation, T=71) (Novick and Kelly). Patient may appear to show a lack of motivation.

b) Patient may be at risk for revictimization (scapegoating) in groups. Hazell, C. Imaginary Groups (Bloomington, Indiana: Authorhouse, 2005). “Certain factors typically make an individual or subgroup a candidate to become a repository for unwanted group parts. Individual history can prime an individual or subgroup to receive a certain type of group projection. Individuals, for example, who have been designated as black sheep in families (Family Discord, T=65; Social Alienation, T=71) may be predisposed to become scapegoats in groups.

c) As a victim of scapegoating and abuse (Family Discord, T=65; Social Alienation, T=71), patient may have an elusive personality (Shengold). Patient cannot reveal essential aspects of his personality to the therapist. Patient will be criticized as non-disclosive. Jerry M. Wiener, M.D., Psychiatry Department Chair, GW, said to patient in August 1993: “You can’t reveal yourself.” The patient’s lack of significant manifest distress
might be consistent with a personality that dreads sadness and that is unable to mourn, i.e., an individual who employs idealization as a manic defense against mourning and loss (see paragraph 2, above). See Goldsmith, R.E. and Freyd, J.J. “Awareness for Emotional Abuse.” Journal of Emotional Abuse, 5(1): 95-123; 2005 (there is a connection between emotional abuse and difficulty identifying emotions).

d) As a victim of scapegoating and abuse (Family Discord, T=65; Social Alienation, T=71) patient may have a tendency to massive splitting (a split between observing and experiencing egos) and isolative defenses (a split between thought and feeling) (Shengold). Patient may be unable to express feelings in therapy.

e) As a family scapegoat (Family Discord, T=65; Social Alienation, T=71) patient might have had a sibling who was idealized by the family of origin (Everett and Volgy).

f) As a victim of scapegoating and abuse (Family Discord, T=65; Social Alienation, T=71) patient may have had a past in which important others were controlling, overly-critical, punitive, judgmental, and intrusive.

This type of family background is conducive to the development of introjective (versus anaclitic) personality pathology (Blatt and Schichman). Individuals with an introjective, self-critical personality style may be more vulnerable to depressive states in response to disruptions in self-definition and personal achievement as opposed to anaclitic concerns centering on libidinal themes of closeness, intimacy, giving and receiving care, love, and sexuality. In anaclitic depression the development of a sense of self is neglected as these individuals are inordinately preoccupied with establishing and maintaining satisfying interpersonal relationships.

Introjective depressive states center on feelings of failure and guilt centered on self-worth. Introjective depression is considered more developmentally advanced than anaclitic depression. Anaclitic
depression is primarily oral in nature, originating from unmet needs from an omnipotent caretaker (mother); while introjective depression centers on formation of the superego and involves the more developmentally advanced phenomena of guilt and loss of self-esteem during the oedipal stage. Patients with introjective disorders are plagued by feelings of guilt, self-criticism, inferiority, and worthlessness. They tend to be more perfectionistic, duty-bound, and competitive individuals, who often feel like they have to compensate for failing to live up to the perceived expectations of others or inner standards of excellence. What is common among introjective pathologies is the preoccupation with more aggressive themes (as opposed to libidinal) of identity, self-definition, self-worth, and self-control. In the pathologically-introjective, development of satisfying interpersonal relationships is neglected as these individuals are inordinately preoccupied with establishing an acceptable identity. 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.

6. Patient has high executive functioning (perfect score on Wisconsin Card Sorting Test):

a) The patient has an unusual ability to ascribe mental states to others; is able to model and understand the internal, subjective worlds of others, making it easier to infer intentions and causes that lay behind observed behaviors; and an unusual ability to judge the emotion in another person’s gaze. Decety, J. and Moriguchi, Y. “The Empathic Brain and its Dysfunction in Psychiatric Populations: Implications for Intervention Across Different Clinical Conditions” (describing characteristics associated with high executive functioning).

b) The patient will tend to be viewed as paranoid by others. Patient’s MMPI paranoia scale (Scale 6) was high (T=83), but this score should
be interpreted in light of his WISC perfect score, i.e., his high executive functioning. Indeed, Anastasi points out that an elevated Scale 6 (Paranoia) can indicate paranoia, or, alternatively, a “curious, questioning and investigative personality.”

7. The MMPI results suggest a creative personality. MMPI-2 scales with significant correlations to the C (creativity) scale are Scale 4 (psychopathic-deviate, T=69), Scale 5 (femininity, T=76), Scale 9 (not significant; but viewed as psychotically manic by three psychiatrists), and Scale O (social introversion, score not provided); as well as GF (gender female, T=57), MAC-R (admitted addiction scale, T=65), ES (ego strength) (perfect score in Wisconsin Card Sorting Test), and SOD (social discomfort, T=81). Nassif, C. and Quevillon, R. “Creativity Scale for the MMPI-2: The C Scale.”

Patient had a statistically significant score on the schizotypy scale (MMPI, T=67). Schizotypy can be associated with creativity, that is, an adaptive ability to associate ideas in unusual ways. Fink, A. et al. “Creativity and Schizotypy from the Neuroscience Perspective.” Schizotypy correlates with social anhedonia. See KwapiL.

The high psychoticism score (MMPI, T=66) combined with high executive functioning (perfect score on the Wisconsin Card Sorting Test) is consistent with high creative potential. Fodor, E. “Subclinical Manifestations of Psychosis-Proneness, Ego Strength, and Creativity” (ego strength appears to combine with psychosis-proneness to favor creative performance).

Creativity has been shown to correlate with the following characteristics: aggression, autonomy (independence), psychological complexity and richness, and ego strength (will); creative persons’ goal is found to be "some inner artistic standard of excellence." Patient may have difficulties in groups that place a premium on abasement, affiliation, and deference (socialization); groups whose goal is to meet the standard of the group (MacKinnon).
Patient also had expansive, detailed, and unusual responses on the Rorschach; he completed the Rorschach protocol then repeated the protocol with the cards turned upside down. That is, the patient completed the Rorschach protocol twice. See Myden, W. “An Interpretation and Evaluation of Certain Personality Characteristics Involved in Creative Production.” In: A Rorschach Reader at 165-65. Edited by M.H. Sherman. (New York: International Universities Press, 1960).

Myden found the following characteristics in persons with expansive, detailed and unusual responses on the Rorschach:

— Subject has a sense of psychological role in life, a concept that denotes inner tendencies, deeply embedded in the personality of subject, not easily modified, which determine nearly all meaningful relationships. (Caligor states that personality rigidity is characteristic of higher level character pathology; it is not clear if personality rigidity is exclusively pathological). This does not mean that it is not possible for subject to act in a manner that is inconsistent with that role, but when doing so anxiety will probably result, and consequently impair the degree of efficiency with which his life’s problems are handled. Since subject’s sense of role in life represents a more or less definite conception of reality and of his role in it, a change from such a basic concept is difficult and unlikely. Subject is apt to be independent of the opinions of others, and is apt to be more original and creative. This requires more intellectual effort than does conformity.

— Subject is apt to investigate the causes of things; hence, while his rate of learning may be slower, its effects are more lasting. (Compare: A high MMPI Scale 6 (Paranoia) can indicate a “curious, questioning and investigative personality.”)

— Subject has an ability to create new personalized constructions and the capacity for inner creation and living more within himself than in the
outer world. Consequently, subject is apt to put intellect before feeling; that is, his relations with others are not apt to be easy or fluent. Subject is introverted, and has a tendency to drain off energy into grandiosity and obsessional ruminations or into original conceptions.

–Subject has markedly stronger feelings about interpersonal relationships than noncreative persons; subject’s interpersonal relations involve greater intensity. Subject has a consequent tendency to withdraw from unpleasant interpersonal situations.

–Subject accepts id drives and fears, and handles them through a strong ego (compare perfect score on the WISC, indicating high executive functioning), which is constantly engaged in reality testing. Subject reaches out for every form of clue in his environment and retains almost every bit of information, which evidently helps to satisfy his need for intellectual control of his relationships with the outer world. Subject is sensitive to every nuance of reaction from the outer world as it pertains to him.

a) Creative persons are independent in thought and action. Compare high MMPI Scale 4 (psychopathic deviate).

b) Creative persons question authority and are fault finders. They regard authority as arbitrary, contingent on continued and demonstrable superiority. When evaluating communications, they separate source from content, judge and reach conclusions based on the information itself, rather than whether the information source was an “authority” or an “expert” (or therapist). Compare high MMPI Scale 4 (psychopathic deviate).

c) Creative persons have an ability to invest effort in idea production (Parnes).

d) Creative persons are drawn to unconscious motives and fantasy life (Frank Barron). (Patient may have a deep-seated aversion to CBT).
8. Patient is intellectually gifted (IQ score in top 2%, verbal IQ top 1%).

a) Studies show a correlation between high IQ and the personality trait called “openness to experience.” Openness to experience is associated with imagination (fantasy), attentiveness to inner feelings, intellectual curiosity, a motivation to engage in self-examination, and a fluid style of consciousness that allows individuals to make novel associations between remotely connected ideas (i.e., free association). (Patient may have a deep-seated aversion to CBT).

b) Giftedness is associated with uncanny intuition. Compare high mentalization ability associated with high executive functioning (Grobman). See paragraph 6a, above.

c) Giftedness is associated with existential depression. (Compare MMPI depressive score, T=76).

d) Giftedness is associated with deep and complex thoughts.

e) Giftedness is associated with intense curiosity. (Compare paragraph 6b, above. A high MMPI Scale 6 (Paranoia) can indicate a “curious, questioning and investigative personality.”)

f) Giftedness is associated with remarkable memory. Patient’s expansive and detailed responses on the Rorschach (he completed the Rorschach protocol twice) suggest a remarkable memory.

g) Gifted persons are very independent, autonomous — (compare high MMPI Scale 4 (Psychopathic Deviate)) — and less motivated by rewards and praise.

h) Giftedness can be associated with introversion.
i) Giftedness can be associated with feeling different, out of step with others, and having a sense of alienation and loneliness.
Psychological Evaluation

Confidential

Name: Gary Freedman
Dates of Evaluation: 2/24/2014
Date of Birth: 12/23/1953
Age: 60
Evaluator: David Angelich, Psy.D.

Reason for Referral:

Mr. Freedman sought a psychological evaluation in order to obtain more information about a diagnosis for himself. Mr. Freedman was evaluated in 1994 at George Washington University, but he did not receive a diagnosis from this assessment. He is currently seeking more specific information regarding a possible personality disorder diagnosis. Overall, this evaluation is thus requested to provide more information about Mr. Freedman’s emotional functioning to clarify treatment planning.

Assessment Measures:

Millon Clinical Multiaxial Inventory – 3rd Edition (MCMI-III)
Minnesota Multiphasic Personality Inventory – 2nd Edition (MMPI-2)
Clinical Interview with Mr. Freedman
Consultation with Mr. Freedman’s psychiatrist, Dr. Shreiba
Behavioral Observations

Relevant Background Information:

Family Background. Mr. Freedman is the younger of two children. He has an older sister who is six years his senior. Mr. Freedman described a
difficult and traumatic childhood. Mr. Freedman’s father was physically abusive toward him beginning at an early age. Mr. Freedman’s father was also physically abusive towards Mr. Freedman’s mother, attempting to strangle her to death at one time during Mr. Freedman’s childhood. Mr. Freedman described poor, abusive backgrounds of both of his parents as well. Mr. Freedman reported that he felt more intense anger at his mother for not protecting him from his father’s abuse, as opposed to conscious anger at his father.

Mr. Freedman’s parents have both been deceased since Mr. Freedman was in his 20’s. Mr. Freedman reported that he recalled feeling very little emotional responses when his mother passed away.

**Relationship History.** Mr. Freedman has been in one romantic relationship with a woman, which occurred when he was in his twenties. This relationship ended due to the woman’s insistence on marriage, which did not interest Mr. Freedman. This relationship lasted for one year. Mr. Freedman described little interest in pursuing a romantic relationship at the current time.

**Educational/ Work History.** Mr. Freedman is a Penn State graduate for his journalism degree, and he has a Law Degree from Temple University. He received a Master of Laws from American University as well. During High School Mr. Freedman had few friends and ended one friendship due to the intense shame he felt about the abuse he suffered in his home growing up.

Mr. Freedman worked at the Franklin Institute beginning at the age of 16. He did editorial work and also managed a scientific publication at one time. Following his Master of Laws Degree, Mr. Freedman worked at a Law Firm doing legal research for approximately three and a half years. This job ended after Mr. Freedman described being overlooked for promotions despite earning high marks on his reviews. Mr.
Freedman discussed feeling that he was being treated unfairly at the firm with fellow employees spreading rumors about him to damage his reputation. Mr. Freedman’s employment with this law firm ended, and Mr. Freedman did not return to work. He qualified for disability benefits at this time due to a mental health diagnosis.

**Medical History.** Mr. Freedman had scarlet fever as a young child. He also had an accident as a young child, where he fell with a curtain rod hitting him in his mouth resulting in significant bleeding.

**Psychiatric History/ Previous Treatment.** Mr. Freedman described wanting to see a psychiatrist since High School, but his parents would not permit this. In 1990, he began seeing a psychiatrist to work on family related problems. This treatment lasted for one year. In 1991, a psychologist treated Mr. Freedman for 20 weeks for hypnotherapy, but he was ultimately deemed not able to be hypnotized. In 1992, Mr. Freedman began treatments with psychiatric residents at George Washington University. Mr. Freedman reported that he did not want to take medication at this time. In 1999, Mr. Freedman began taking medication in the form anti-depressants. In 2001, he began taking Zyprexa which he stated was not helpful. Mr. Freedman has been taking Paxil for several years, which he states does stabilize his mood. He also takes Geodon, which he does not feel is helpful. Very recently, Mr. Freedman stopped taking Klonopin, which he reported has him feeling somewhat anxious.

Regarding substance abuse, Mr. Freedman drank a six-pack per day for two years from 1994 to 1996. He stopped on his own accord without specific treatment.

Mr. Freedman attempted suicide in 1977 by overdose (age 23). He was found unconscious while living with his mother. He was not
hospitalized at this time. Mr. Freedman has not been hospitalized for psychiatric problems.

**Behavioral Observations/ Mental Status:**

Mr. Freedman is a 60-year-old male of average stature who appears in good health. On the date of his evaluation he was dressed casually and appropriately. His thought processes were coherent, intact and goal directed. Mr. Freedman’s affect was somewhat flat. His mood appeared to be mildly depressed and anxious at times, but stable. He did not complain of depression. Mr. Freedman appeared somewhat anxious about the testing, but he gave good effort. Mr. Freedman was cooperative with voicing his thoughts through the interview and testing process. His judgment appeared poor to fair based on his interview process with this evaluator. Testing results are felt to represent an accurate estimate of his current emotional functioning.

**Emotional/ Personality Functioning:**

The MCMI-III and the MMPI-2 were given to assess Mr. Freedman’s personality and emotional functioning. The MCMI-III and MMPI-2 are structured personality measures that was administered to Mr. Freedman to determine the extent to which he may be experiencing psychiatric symptoms in addition to finding out more about his general personality make-up. Mr. Freedman’s profiles on the MCMI-III and MMPI-2 are consistent with his current presentation and congruent with his history. Test results are considered to represent a valid measure of his personality and current mental state.

The MCMI-III reports T Scores for the clinical measures and scales. A T score of 65 or above is considered statistically significant. On the Severe Clinical Syndromes Scales, Mr. Freedman obtained a T Score of 72 on the Delusional Disorder Scale. On the Severe Clinical Personality
Patterns Scales, Mr. Freedman’s test profile revealed a T-Score of 67 on the Schizotypal Personality Pattern Scale. On the Clinical Personality Patterns Scales, he obtained a T Score of 105 in the Narcissistic Scale. Also in the Clinical Personality Patterns Scales, Mr. Freedman obtained a T-Scores of 65 and above (considered statistically significant) on the following scales: T Score of 85 in the Schizoid Scale, 78 on the Avoidant Scale and a T Score of 76 on the Depressive Scale.

Mr. Freedman’s MMPI-2 clinical scales showed elevations on 4 overall scales: the Psychopathic Deviate Scale #4 with a T Score of 69, the Paranoia Scale #6 with a T score of 83, the Social Introversion Scale #0 with a T Score of 70, and the Masculinity- Femininity Scale #5 with a T Score of 76. T scores are considered statistically significant if they are 65 or above. The two tiered personality code types are the most solidly supported by research. When a subject has several elevated clinical scales, the most salient features of each personality code type are used to describe the test subject. Mr. Freedman’s elevated Clinical Scales correspond primarily to the 4-6/6-4 personality code types.

Persons with the 4-6/6-4 code type are immature, narcissistic, and self-indulgent. They are passive-dependent individuals who make excessive demands on others for attention and sympathy, but they are resentful of even the mildest demands made on them by others. They do not get along well with others in social situations, and they are especially uncomfortable around members of the opposite sex. They are suspicious of the motivations of others and avoid deep emotional involvement. They generally have poor work histories and marital problems are quite common. They appear to be irritable, sullen, and argumentative. They seem to be especially resentful of authority and may derogate authority figures.

Individuals with the 4-6/6-4 code type tend to deny serious psychological problems. They rationalize and transfer blame to others,
accepting little or no responsibility for their own behavior. They are 
somewhat grandiose and unrealistic in their self-appraisals. Because 
they deny serious emotional problems, they generally are not receptive 
to traditional professional counseling or therapy. In general, as the 
elevations of scales 4 and 6 increases and as scale 6 becomes higher 
than scale 4, a pre-psychotic or psychotic disorders becomes more 
likely. They present with vague emotional and physical complaints. 
They report feeling nervous and depressed, and they are indecisive and 
insecure.

Overall testing results support the diagnosis of a Delusional Disorder-
persecutory type along Axis I. It is noted that Mr. Freedman was 
administered the Wisconsin Card Sorting Test at The George University 
Medical School in March 1996 and achieved a perfect score (6 errors). 
As noted in this previous 1996 evaluation, the reader is reminded that 
Mr. Freedman’s delusions are without prominent mood symptoms, 
auditory hallucinations or a formal thought disorder. Mr. Freedman 
also did not report symptoms of mania as demonstrated by his T score 
of 36 on Scale 9 (Mania). Mr. Freedman did earn a T score of 70 on the 
Social Introversion Scale, Scale 0. On another content measure of 
Social Introversion, the SOD Scale, Mr. Freedman earned a T Score of 
81. Although diagnosed with Alcoholism in the past, Mr. Freedman did 
not report significant addiction difficulties in the present evaluation; he 
earned a T Score of 48 on the MAC-R Scale (Addiction Proneness). Mr. 
Freedman earned a T score of 43 on the Es content scale (Ego 
Strength).

Regarding Axis II, and personality disorders, Mr. Freedman has 
prominent features of several different personality disorders, as noted 
in his MCMI-III results as well as the MMPI-2 as noted above. It is felt 
that he can best be described as having a Personality Disorder, NOS 
with Prominent Narcissistic, Schizoid, and Avoidant Traits with 
Depressive Personality Features.
**Recommendations:**

Continued medication management as well as long-term therapy is recommended for Mr. Freedman.

It was truly a pleasure working with Mr. Freedman to complete this evaluation. If you have any questions or need additional information, please do not hesitate to contact Dr. Angelich at (202) 494 6722.

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Clinical Psychologist  
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PERSONAL COMMENTS

A serious limitation in Dr. Angelich’s narrative report is that the selective raw test data on which the report is based are remarkably similar to the psychological test results of Ted Kaczynski, the so-called Unabomber. The problem is that Mr. Kaczynski is a serial killer and a domestic terrorist. I am not a serial killer or a domestic terrorist.

The following text is a brief excerpt from the forensic report filed by psychiatrist Sally Johnson, M.D. in Mr. Kaczynski’s criminal prosecution.

The WAIS-R results (IQ) were Verbal Score of 138, Performance Score of 124, and Full Scale Score of 136.

People with the 4-6 two point code pattern (as evident in Mr. Kaczynski’s profile with Scale 4=69, Scale 6=68) are described as viewing the world as threatening and feeling misunderstood or mistreated by others. Such people can be hostile, irritable, and demanding. They are commonly very self-centered and are not concerned about the rights of others. Indeed, they are often resentful of the success of other people and suspicious of their motives. In addition, these people can be impulsive and manipulative, frequently getting into conflict with family and authorities. They often have unstable family lives, personal relationships, poor work and educational histories, and legal problems. This profile is associated with stable characteristics and such people are very resistant to treatment interventions. They often deny that they have problems and are evasive about discussing them, sometimes refusing to talk about personal shortcomings at all. They avoid close relationships and have trouble getting along with those people with whom they do come in contact, including family members. Such people have vague goals and are indecisive about many aspects of their lives.

Similar to the MMPI-2, Mr. Kaczynski’s responses to the Millon Clinical Multiaxial Inventory, Second Edition might be described as forthright
and self-revealing. His pattern of item endorsement does not suggest overt attempts to exaggerate nor minimize psychological problems, and to the contrary appears to reflect a balance between self-protective and potentially self-effacing responses. The resulting clinical scale profile is viewed as a useful indication of his current personality functioning.

Modest elevations are present on clinical scales: Schizoid (1)=73; Avoidant (2)=71; Sadistic Aggressive (6B)=78. Persons with similar test results typically exhibit difficulties primarily characterized by hostile alienation. These persons often espouse overt disregard for or anger at significant others and other people in general. They may avow few or no attachments to others and deny experiences of either positive sentiments or feelings of guilt or shame. They tend to relate to others primarily through threats or hostile posturing, or overt aggression, but may prefer outright avoidance of social contacts. They are often seen as dogmatic and unyielding, and may espouse unusual social, political or religious ideas. They often view others as devalued and unimportant and may act in ways that others see as cold, unfeeling, or callous. Formal disorder in the flow and form of thought is not generally associated with this pattern of results, and marked sensory disturbances are not typically noted.