Thoughts about Therapy Sessions

The Dream of the London Hotel

Introduction

In her novel about psychoanalysis, *August*, Judith Rossner writes about the fictional analyst, Lulu Shinefeld who treats a patient who purchased a copy of two books by Freud. During the analysis the patient lifted dreams out of Freud's *Interpretation of Dreams* and presented them to Dr. Shinefeld as if the dreams were his own. After a time, Dr. Shinefeld came to see what the patient was doing but thought that the fact that the patient had chosen those dreams had analyzable meaning. Rossner writes: "During the time between his accepting Dr. Shinefeld and actually coming into the office (his third scheduled appointment), he purchased An Outline of Psychoanalysis and The Interpretation of Dreams. . . . He'd been with her for a few weeks before she was confirmed in her suspicion that material he was bringing in consisted of simple alterations of basic dreams he'd found in the book. When she said that there was probably still meaning in his selection of dreams, he stopped telling them to her at all."

I read *August* in 1984 when I was 30 years old, before I had developed a deeper appreciation of psychoanalysis. At the present time I can remember only one incident from the book, and it is the quoted passage above. I was deeply impressed and intrigued with the analytic view that everything is analyzable. Even the patient's evasion of the analytic work, as Rossner describes, or the patient's attempts to destroy meaning are analyzable issues. At a therapy session on I reported a dream I had had the previous evening and I discussed my associations to the dream. At the conclusion of my dream report, I said: "I can't wait to get home and write up my thoughts. At this very moment I am trying to think of a title for the dream." My therapist appeared to become irritated. She viewed my independent self-analysis as self-defeating; that I was destroying the meaning of our therapy relationship. My therapist's comments had a critical tone.

But is it even possible for a patient to successfully obliterate meaning? Are not the very strategies that the patient uses to defeat the analytic work themselves analyzable? Doesn't the principle of psychic determinism—namely, the view that everything a patient says and does in the analysis is related to everything else about the patient
and that conscious thoughts and behaviors have unconscious determinants—also apply to a patient’s self-defeating behaviors and attempts to destroy meaning? Once again, in analysis, isn't everything a patient says and does in the session simply analyzable - doesn't everything a patient says and does constitute communications that have unconscious determinants, communications that have meaning? I would say that my statement, "I can't wait to get home and write up my thoughts" even if considered an attempt to evade the therapy work, is itself unconsciously determined and meaningful as well as related to everything else that I talked about at the session.

Indeed, the very dream I related to my therapist at this session on January 30 contained the following thought: “I am truly lost, utterly lost, with no hope of getting back [home].” And didn't one of my previous significant dreams contain the thought, “How am I going to get home?” (See The Dream of Schubert's Final Piano Sonata). I note, incidentally, that in Homer's Odyssey, “the return home” is the overarching theme of a book about a journey: a metaphor for psychic exploration. My therapist interpreted my statement “I can't wait to get home and write up my thoughts” as a concrete, literal reference to my physical absence from the therapy situation. Perhaps, a more sophisticated and psychoanalytically-attuned listener might think about the ways in which I was not talking about physical absence at all, but psychical absence: a retreat from the present moment to an inner, psychic world that was overfull with the traumatic experiences of past generations.

I refer to the work of the analyst Haydée Faimberg, whose book, The Telescoping of Generations attempts to "explain the [nonverbal] transmission of a history that at least partially does not belong to the patient's life and that is clinically revealed . . . as a constituent of the patient's psyche." Faimberg, H., The Telescoping of Generations. Faimberg demonstrates how narcissistic links that pass between generations can be unfolded in the intimacy of the session, through engagement with the patient’s private language. She describes the analyst’s narcissistic resistances to hearing what the patient does say, and what the patient cannot say. Is my psychical preoccupation with “going home” a transference phenomenon, a narcissistic identification with my maternal grandmother who immigrated to the United States from Poland with her newlywed husband at age eighteen? She never saw her family again and did not acculturate to the United States.

An analytic listener needs to be alive to all possible interpretations of the patient's material—both what he says and what he cannot say. I had previously talked with my therapist about my family's traumatic past, and even discussed Faimberg’s work with
her. It is my view that only an inexperienced or amateurish analyst would fail to see that the patient's evasion of the work of analysis is itself analyzable. Only an analyst who has no deep understanding of the underlying assumptions of an analytic view of the mind will divide a patient's narrative into two categories: namely, analyzable narrative and un-analyzable narrative. A fundamental principle that emerges from an analytic view of the mind is that all of a patient's narrative fits into only one category, namely, analyzable, unconsciously determined statements that are subject to psychic determinism.

A patient in analysis might consciously try to evade the analytic work, but he cannot evade psychic determinism. Keep in mind, the statement "I can't wait to get home and write up my thoughts," is not simply a statement of intent to engage in a future behavior that bypasses the therapy work, it is also an idea: an association to everything else I said at that session. In my view my statement, "I can't wait to get home and write up my thoughts" carries important meaning about my transference and my resistance to the transference and is in fact analyzable. I attempt to demonstrate this proposition in the following discussion.

Transference Issues Arising at a Therapy Session

I discussed with my therapist a dream I had had the previous evening. I saw the dream as a transference dream that was an expression of the disappointment, I feel about our therapy work.

I am in London, England. I am on vacation. I am walking around the city as a tourist. There are construction sites everywhere. Foundations are being dug. There is mud everywhere, on the streets. In the distance I see a central district with tall buildings, skyscrapers. I have a mix of anxious feelings. I think, “this is not the London I imagined. Where are the old quaint buildings? Where are the types of places you’d like to visit, things of interest to tourists? They are nowhere to be seen. All I see are sights that I would see in any other metropolis, say New York or Philadelphia. I wanted to see the old London, not a modern metropolis. This isn’t what I imagined.” I take videos of the construction sites with my iPod, which I plan to post on my Facebook page. The most severe anxiety concerns the following thought: I had strayed a distance from my hotel and no longer remembered the name of the hotel or the street on which it was located. I thought, “What will I tell a cabbie, how will I direct him to my hotel? I don’t remember the name of the hotel or where it’s located. I am truly lost, utterly lost, with no hope of getting back.”
EVENTS OF THE PREVIOUS DAY: 1. I had sent an email to the IPA (The International Psychoanalytical Association) in London. I attached a text I had written about my therapist, a trainee analyst:

I am concerned about the competence of [redacted], MSW, MBA, LICSW, Washington, DC. [redacted] is a psychoanalyst but I see her in weekly psychodynamic psychotherapy. I have written a document about a recent therapy session, which, in my mind, raises substantial questions about her competency. Could you address my concerns? The text of the therapy write-up is in the attachment.

Gary Freedman

A brief time later, I received the following reply from the IPA:

---Original Message---
From: IPA General
To: Gary Freedman
Sent: Wed, Jan 29, 2020 5:46 am
Subject: RE: analyst competence

Dear Gary,

Thank you for your email, Please note that per the IPA’s Procedural Code, you will need to contact the Ethics Department from the organization [redacted] is affiliated with directly. Per our records, [redacted] is currently an IPA Candidate in training via the Washington Baltimore Center for Psychoanalysis. The Chair of the Ethics Committee at the centre is Dr. Martha Dupecher, and the process for raising an ethics complaint at the centre can be found here. Kind regards, Lucila Riascos Weber Membership Services Secretary

I then sent the following email to Martha Dupecher, Ph.D.

Dr. Dupecher:

I am in weekly psychotherapy with an analyst-in-training at the Washington Baltimore Center for Psychoanalysis. I am concerned that although my therapist is outstanding that she is not at a level of training that is suitable for my needs. I wrote some thoughts about our work together that suggests that my therapy relationship with her is not a good fit. I have maintained my
therapist’s anonymity. May I interest you to take a look at what I wrote about a recent therapy session?

Gary Freedman
Washington, DC

Dr. Dupecher did not reply.

1-- Later, in the evening, I watched an episode of the TV series Upstairs, Downstairs, from the 2010 production. The drama is about an upper-class family, the Holland family, that has purchased 165 Eaton Place in London in 1936, some years after the Bellamy family sold the premises in 1930. The Bellamy saga was the subject of previous Upstairs, Downstairs productions that were broadcast in the 1970s. I was a big fan of both the old series and the more recent shows from 2010 and 2012. I watched the opening episode that I had previously seen in the year 2010. In the beginning of the episode the former Bellamy maid, Rose Buck, who now runs a domestic servant agency, returns to 165 Eaton Place as housekeeper to the new owners, the Hollands. I found the following scene early in the story emotionally powerful. Rose Buck enters the grand house. She is alone. The house is empty and in great disrepair. She walks around, apparently moved by returning to the house where she had worked for 40 years (“This isn’t what I imagined”). I projected onto the character Rose Buck painful feelings of nostalgia and loss.

2-- Earlier in the day I learned via a Google search that my college English instructor, Ellen Furman had died at age 76 in 2018. It was Mrs. Furman who introduced me to The Great Gatsby by Fitzgerald and other works of literature by Hemingway and Faulkner (As I Lay Dying).

Random Thoughts:

I link the dream to anxious feelings I have about my therapist and our work. I had such high hopes about embarking on therapy with her last February 2019. I had idealized feelings about seeing a psychoanalyst (perhaps symbolized in the dream by my idealized notions about “quaint old London”). These idealized imaginings were never realized. I saw that my therapist was not fundamentally different from any therapist symbolized perhaps by the sense that the London I saw was just a generic metropolis like New York or Philadelphia. “I could have saved a trip to London and just gone to New York.” I could have seen any therapist, not a psychoanalyst.
suspect that the hotel room to which I cannot return is the analyst’s office. One stays in a hotel room for a time-limited period, just as one stays in the analyst’s office for a time-limited period. One rents the hotel room; one rents the analyst’s time in a room. I think of the fact that my 1990 dream about my previous therapist, the psychoanalyst, Stanley R. Palombo, M.D. (The Dream of the Birthday Cake) took place at a hotel, once again, the analyst’s office. Dr. Palombo’s professional office was in an apartment building. This London dream is related to the dream I had the night before my first session with my therapist on February 21, 2019 (The Dream of the Borromean Islands). I associated that dream to idealized feelings I had about a trip I had made to Stresa, Italy in 1978. I associated those idealized feelings about Italy to my eager anticipation, mixed with anxiety, of seeing a psychoanalyst the next day. I took pictures in that dream also, just as I took videos in this dream. I suspect there are issues of phallic-urethral urgency in the London dream, as symbolized by the London skyscrapers. The skyscrapers symbolize the erect penis. I suspect that the London construction sites in the London dream symbolized the process of psychoanalysis, that is, digging into the unconscious. I had positive feelings about the construction work; I took videos of the work and planned to post the videos on the Internet. (In this very letter, I am, figuratively speaking, taking “pictures” of my dug-up unconscious.)

I see the following themes in the London dream: Disappointed idealization and disillusion. I had expected so much from seeing quaint old London (seeing a psychoanalyst) and I was disappointed and disillusioned. London was just a generic metropolis (my therapist was like any other therapist, not a psychoanalyst). The London dream symbolizes my desire for and anxieties about analysis (symbolized by the construction work, that is, digging up the unconscious and the fear of getting “soiled by the mud”). I see symbolism in the London dream relating to possible phallic-urethral urgency (symbolized in the dream by the London skyscrapers) which Freud and Erikson linked to ambition (“I will email this document to the IPA and the IPA will think I am a psychoanalytic genius!”).

Erikson writes in Insight and Responsibility: “At the end of Freud’s dream of Count Thun, there is also an unknown man seemingly a victim of the ambitious dreamer’s wish to escape infantile shame and to prove that he is ‘somebody.’” In contacting the IPA was I attempting to prove that I was “somebody?” Was I attempting to overcome feelings of shame I experience with my therapist? (“My therapist makes me feel worthless and castrated. I will show her. I will write to the IPA and prove my worth.”) Was I attempting to be “rescued from obscurity?”
We can see feelings of loss and nostalgia in the London dream (that I projected onto the Upstairs, Downstairs character Rose Buck); I had expected that seeing a psychoanalyst in February 2019 would revive the positive feelings I had with Dr. Palombo in 1990, but that never materialized.

The day following the dream I discussed with my therapist my thoughts about the London dream as well as the fact that I had sent an email about my therapy to the IPA. My therapist’s comments were limited to the following: “You have a desire for power and control.” She thought the dream was about power and control. She saw issues of power and control in my contacting the IPA; I saw grandiosity — “I will be famous! They will think I am a genius!” When I told my therapist that I was looking forward to going home to do a write-up of the London dream, she said that I was “destroying meaning.” She meant that the only valuable meaning of the dream would come from my therapy work with her, not my self-analysis. She thinks my self-analysis is a process of destroying the meaning of my actual therapy with her.

As I see it, my therapist devalues any expression of my autonomy, which I see as promoting my engulfment fears (and also my feelings of shame).

One last thought. Freud lived his final year in London, an exile from Nazi-occupied Austria, and died there in 1939. A portion of my autobiographical historical novel, Significant Moments describes Freud’s flight to England and his death by euthanasia in London in September 1939:

still night George Gordon, Lord Byron, Manfred. Then, land!—then England!
Elizabeth Barret Browning, Aurora Leigh. reaching the other shore Commentary on
the Diamond Sutra. the first eight weeks of freedom Johann Wolfgang von Goethe,
The Flight To Italy. Diary and Selected Letters (editor’s note). June, May . . .
April . . . February . . . November Simon Gray, Butley. September Johann Wolfgang
von Goethe, The Flight To Italy. Diary and Selected Letters (editor’s note). this long
disease Simon Gray, Butley. his daughter Anna Peter Gay, Freud: A Life for Our
Time. Freud, Living and Dying Max Schur, Freud, Living and Dying. —his death and
her sorrow— Joseph Conrad, Heart of Darkness. the final summons James Fenimore
Cooper, The Last of the Mohicans. ‘What is it—what?’ Robert Frost, Excerpt from
Martin Gregor-Dellin, Richard Wagner: His Life, His Work, His Century. his loyal
and loving physician Peter Gay, Freud: A Life for Our Time. the morphine Jack
Our Time. syringes and needles Alan Dershowitz, Reversal of Fortune: Inside the
von Bulow Case. (A syringe figures prominently in two other dreams in this book:
The Dream of the Botanical Monograph and The Dream of the Intruding Doctor).

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The scene in Upstairs, Downstairs in which the maid Rose Buck returns in 1936 to
her old place of work, 165 Eaton place six years after she had left the Bellamy
household in 1930 reminds me of the text at the end of my book, Significant
Moments, which talks about Freud’s former home at Berggasse 19 in Vienna. The
Upstairs, Downstairs character, Rose Buck had lived nearly half a century at 165
Eaton Place, but there was no scent of the past left—:

For many years no sign existed on the house where Freud lived in Vienna. Taxi
drivers who were asked by tourists to drive to the “Freud House” looked blank. In
1953 the house was finally rescued from obscurity. The World Federation of Mental
Health, with permission from the Austrian government, attached a plaque to the
building saying, “From 1891 to 1938, in this house, lived and worked Professor
Sigmund Freud, creator and founder of Psychoanalysis.” The apartment, however,
remained occupied by a tenant and was not accessible to the public. In November
1969 a “Sigmund Freud Gesellschaft” was founded in Vienna with the objective of
restoring the Freud apartment and founding a museum. I went to Vienna right after
the apartment had been vacated. It was thoroughly dilapidated and common
looking. Edmund Engelman, Berggasse 19: Sigmund Freud’s Home and Offices,
Vienna,1938. Endless suites of rooms, here and there the parquet flooring still left.
Boris Pasternak, Dr. Zhivago. I walked through the badly abused premises; little sign of their former dignity remained. The beautiful tile stoves had disappeared and had been replaced by ugly heating devices. I did not notice any major structural changes. But I was overcome by the emptiness of the rooms I walked through. Edmund Engelmann, Berggasse 19: Sigmund Freud’s Home and Offices, Vienna, 1938. Freud had lived here nearly half a century, but there was no scent of him left—Erica Jong, Fear of Flying. Now, in this old familiar room, it is more like the sorrow of a dream . . . H.G. Wells, The Time Machine. I thought Sigmund Freud, The Interpretation of Dreams. . . . than an actual loss. H.G. Wells, The Time Machine. Mentally, I set all the pieces of furniture in their place. I looked at the wall where . . . Edmund Engelmann, Berggasse 19: Sigmund Freud’s Home and Offices, Vienna, 1938. . . . if I remembered right, the . . . Sigmund Freud, The Interpretation of Dreams. . . . couch had been and noticed, on the wooden floor, the outline of the couch . . . Edmund Engelmann, Berggasse 19: Sigmund Freud’s Home and Offices, Vienna, 1938. . . . the famous couch in Dr. Freud’s office. Harold Bloom, The Western Canon: The Books and School of the Ages. A week later, before leaving Vienna, I went back to Berggasse 19 once again. Workmen had already started to put the offices and apartment into shape. The floor had been scraped and polished. The ghost of the couch had disappeared. Edmund Engelmann, Berggasse 19: Sigmund Freud’s Home and Offices, Vienna, 1938.

Possible Transference Issues

At the therapy session on the day following the dream I told my therapist that I had sent an email about our work to the International Psychoanalytical Association (IPA). I said to my therapist: “I’m looking forward to going home and doing a writeup of the dream.” My therapist’s only comment was—“By working on this material on your own rather than talking about it here you are draining the meaning out of your material” and “you are concerned with power and control.” My therapist did not address any of the transference issues suggested by my behavior, which I will elaborate here.

1—Depressive Anxiety: To what extent does my “self-analysis,” my longing to understand myself, relate to my need to get in touch with an internalized good object? Klein writes: “The longing to understand oneself is also bound up with the need to be understood by the internalized good object. One expression of this longing is the universal phantasy of having a twin . . . . This twin figure [] represents
those un-understood and split off parts which the individual is longing to regain, in the hope of achieving wholeness and complete understanding; they are sometimes felt to be the ideal parts. At other times the twin also represents an entirely reliable, in fact, idealized internal object.” Klein, M., “On the Sense of Loneliness.” Does the “hotel” of the London dream, as well as my reference to “home” at the clinical session, represent for me the good object from which I am estranged? When I said at the session, “I can’t wait to get home and write up my thoughts” was I really saying “I can’t wait to regain my split off parts, the ideal parts, and thereby achieve wholeness and complete understanding?” To what extent is my “self-analysis” a defense against depressive anxiety? One viewpoint is that Freud’s self-analysis was part of a defense against depressive anxiety: From a Kleinian viewpoint, the psychoanalyst Didier Anzieu considered Freud’s “elaboration of psychoanalytic theory . . . corresponded to a setting up of obsessional defenses against depressive anxiety” — emphasizing Freud’s need to “defend himself against it through such a degree of intellectualization.”

2-- Revival of Feelings about my Mother: To what extent is my reliance on self-analysis at the expense of my therapy relationship a revival of my early feelings about an unempathic mother, and my adaptive response of needing to moderate my self-states on my own in the face of a lack of maternal soothing? In childhood, I was forced to face my psychic pain on my own. I did not have a mother who would respond meaningfully to my self-states. My impaired ability to share myself in therapy might relate back to my response to an unempathic mother.

3-- Response to Trauma:

To what extent is my inability to share myself in therapy a response to a traumatic childhood that promoted the development of a dismissive-avoidant attachment style that features a desire to be independent, strong, and self-sufficient? Robert T. Muller, Ph.D. writes: “Intrafamilial trauma is known to be associated with mental health-related challenges that place the individual at risk for the development of psychopathology. Yet, those trauma patients who are primarily dismissing (avoidant) of attachment also demonstrate significant defensiveness, along with a tendency to view themselves as independent, strong, and self-sufficient. Paradoxically, such patients present as highly help rejecting, despite concurrent expressions of need for treatment and high levels of symptomatic distress. Consequently, working with such individuals in psychotherapy can present several challenges. Prior theory and research have suggested that therapeutic change may be facilitated through direct
activation of the attachment system and challenging defensive avoidance. Muller, R.T., “Trauma and Dismissing (Avoidant) Attachment: Intervention Strategies in Individual Psychotherapy.” At age two-and-a-half I suffered an accidental traumatic injury to my oral cavity. A doctor had to cauterize the wound. My mother later told me that there was a lot of bleeding. She later recalled she was afraid I would bleed to death before she could get me to the doctor. Perhaps part of the reason why this was traumatic for me is that I internalized my mother’s panic. I have no idea how my mother got me to the doctor’s office. My parents did not own a car. They did not drive. Maybe my mother took a cab. I do not know. Is it possible my mother was in a panicked state the entire time on the way to the doctor’s office? I have no idea. Does my panic in the London dream relate back to an actual panicked ride in a taxi from childhood? Was the anxiety in the dream about getting back to my hotel a dream representation of an actual event from childhood? Recall the words of the manifest dream: “I had strayed a distance from my hotel and no longer remembered the name of the hotel or the street on which it was located. I thought, ‘What will I tell a cabbie, how will I direct him to my hotel? I do not remember the name of the hotel or where it is located. I am utterly lost, utterly lost, with no hope of getting back.’” I had told my therapist about the childhood injury on two previous occasions but she failed to register the clear connection between the childhood anecdote about a possible panicked ride in a taxi at age two-and-a-half and the London dream. One wonders, as Faimberg would ask: does my therapist show narcissistic resistances to hearing what I say and what I am unable to say?

4—Feelings of Shame in Reaction to my Therapist:

In my dream write-up I suggested that my act of contacting the IPA was a defense against feelings of shame I experience in my therapy relationship: “I see symbolism relating to possible phallic-urethral urgency (symbolized in the dream by the London skyscrapers) which Freud and Erikson linked to ambition (“I will email this document to the IPA and the IPA will think I am a psychoanalytic genius!”). Erikson writes in Insight and Responsibility: “At the end of Freud’s dream of Count Thun, there is also an unknown man seemingly a victim of the ambitious dreamer’s wish to escape infantile shame and to prove that he is ‘somebody.’” In contacting the IPA was I attempting to prove that I was “somebody?” Was I attempting to overcome feelings of shame I experience with my therapist? (“My therapist makes me feel worthless and castrated. I will show her. I will write to the IPA and prove my worth.”) Was I attempting to be “rescued from obscurity?” Blatt writes that “[l]ibidinal concerns [in introjective depression (dismissive avoidant attachment)] are primarily
at the phallic-oedipal level and related to the development of the superego, the
processes of sexual identification, and the beginning phases of the oedipal conflict.
The parents' conscious and unconscious attitudes and feelings about themselves and
their child [] have important effects on the child's conscious and unconscious
feelings about himself and his strivings [with all that implies about the child's
propensity to introject parental anxieties, that is, intergenerational transmission of
parents' and grandparents' anxieties].” Blatt, S.J., “Levels of Object Representation in
Anaclitic and Introjective Depression.”

5- Transference Feelings Suggested by the Dream:

In my dream write-up I associated to feelings of being lost, my loss of contact with an
idealized object or my inability to contact an idealizable object, and my
disillusionment with my present situation. I am reminded of Bion’s patient whose
inability to find an idealizable object (an object able to contain the patient’s feelings
of awe) was associated with a hypercritical attitude toward his analyst, Wilfred Bion.
The analyst Judith Mitrani writes: “The psychoanalyst Wilfred Bion describes a
patient whose attacks on him in analysis, which centered on the patient’s feelings of
disappointment and hostility, did not constitute an attack on the ‘good breast’ or the
analyst’s good interpretations. Neither did Bion seem to see the patient’s fragmented
presentation as the result of an envious attack on thinking or on the links that might
have rendered his communications meaningful and relevant. Instead, Bion appears
to conclude that his patient was attempting to have an experience of an object who
might be able to understand and transform the inchoate experiences of the as-yet-
unintegrated-baby-he and was therefore seeking the realization of his preconception
of an object who could contain these experiences as well as his innate capacity for
love, reverence, and awe.” Were my thoughts in the London dream about my
inability to gain contact with “quaint old London” as well as my anxiety about not
being able to “get back to” my hotel expressions of anguish centering on my inability
to find an object that I could idealize, that could contain my feelings of awe?

6- Revival of the early Mother-Father-Child Triad:

My psychology parallels Kohut’s patient Mr. U who, turning away from the
unreliable empathy of his mother, tried to gain confirmation of his self through an
idealizing relationship with his father. The self-absorbed father, however, unable to
respond appropriately, rebuffed his son’s attempt to be close to him, depriving him
of the needed merger with the idealized self-object and, hence, of the opportunity for
gradually recognizing the self-object’s shortcomings. Kohut, H., The Restoration of the Self. Does the IPA represent for me the idealized but unavailable father that I use as a defense against an inadequate mother (revived in the person of my therapist)?

7- Resistance and Resistance to Transference Resistance is the phenomenon encountered in clinical practice in which patients either directly or indirectly exhibit paradoxical opposing behaviors in presumably a clinically initiated push and pull of a change process. It impedes the development of authentic, reciprocally nurturing experiences in a clinical setting. It is established that the common source of resistances and defenses is shame. Resistance is an automatic and unconscious process. It can be either for a certain period (state resistance) but it can also be a manifestation of more longstanding traits or character (trait resistance). Examples of psychological resistance may include perfectionism, criticizing, contemptuous attitude, being self-critical, preoccupation with appearance, social withdrawal, need to be independent and invulnerable, or an inability to accept compliments or constructive criticism.

Eve Caligor, M.D. states that in psychoanalysis the interventions of the analyst focus on the analysis of resistance and, particularly, on the resistance to transference. Is my self-analysis an expression of resistance? Assuming my self-analysis is an expression of resistance and that my self-analysis, as proposed, is a defense against depressive anxiety, isn’t a productive area of inquiry to assess how depressive anxiety is a source of resistance for me? A major issue in depressive anxiety is guilt. Assuming that depressive anxiety is a factor in my resistance might we label my resistance, in classical analytic terms, as primarily “guilt resistance?” According to Freud, “the guilt that is finding its satisfaction in the disorder refuses to leave the punishment of suffering.” The feeling of guilt (or in Kleinian terms, depressive anxiety) in these cases presents itself as a resistance to healing and is very difficult to overcome. In the London dream does my thought, “What will I tell a cabbie, how will I direct him to my hotel?” in fact concern the resistance? “What will I tell (what am I even able to tell) my therapist about my inner states, about my internal objects? Is this therapist even able to help me to get to my destination? Again: The analyst needs to be alive to all possible interpretations of the patient's material—both what he says and what he cannot say.

At a session in about four months earlier, I said to my therapist: “I feel like I am a customer in a taxicab and you’re the driver. I depend on you to get me where I need to go, but you depend on me for directions. I have feelings of desperation about this
— as if I will never get to the destination, as if my life depended on my getting to the
destination.” At the therapy session at which I discussed the London dream, my
therapist failed to register the connection between that earlier statement with the
manifest content of the London dream. One wonders, as Faimberg would ask: does
my therapist show narcissistic resistances to hearing what I say and what I am unable
to say? And what about the possible connection between the taxi ride in the London
dream and my accidental childhood traumatic injury to the oral cavity at age two-
and-a-half?

To paraphrase my former therapist, the psychoanalyst Stanley R. Palombo, M.D.,
perhaps we might surmise that in the dream I had substituted a metaphor about my
current distressed mental state—my desperate concern that psychotherapy was not
helping me arrive at my destination, “What will I tell a cabbie?”—for memories of a
traumatic childhood injury of equal affective significance. Palombo proposes that by
retracing the substitutions, one can see how a current conflict relates to childhood
experience. See Palombo, S.R., “Day Residue and Screen Memory in Freud's Dream
of the Botanical Monograph.”

8— The Possibility of Intergenerational Transmission

My therapist interpreted my statement “I can't wait to get home and write up my
thoughts” as a concrete, literal reference to my physical absence from the therapy
situation. Is it possible that I was not talking about physical absence at all, but
psychical absence: a retreat from the present moment to an inner, psychic world that
was overfull with the traumatic experiences of past generations? Haydee Faimberg's
book, The Telescoping of Generations attempts to "explain the transmission of a
history that at least partially does not belong to the patient's life and that is clinically
revealed . . . as a constituent of the patient's psyche." Faimberg, H., The Telescoping
of Generations. Is my psychical preoccupation with “going home” a transference
phenomenon, a narcissistic identification with my maternal grandmother? My
grandmother emigrated from Poland to the United States at age eighteen and had no
contact with her family again. She spoke broken English when I knew her and my
father used to ask rhetorically, “how can a person live in a country for fifty years and
never learn the language?” My grandmother’s husband, who brought her to the
United States, died when she was twenty-six, leaving her in poverty in the years
before social welfare programs. I wonder if I have internalized my grandmother’s
losses and her possible survivor guilt: whether her feelings were transmitted to me
intergenerationally. I am intrigued by the fact that at a symbolic level all of the
following issues can be seen to be related: my identification with my grandmother’s 
estragement from her homeland; my narcissistic disturbance in which I feel 
estraged from ideal parts of myself with which I seek to re-unite like a foreigner who 
longs for her homeland; the sense of myself as an outsider in my family; and 
fantasies about finding myself in an unfamiliar place and longing, either covertly or 
implicitly, to go home. And then, also, there is the symbolic equivalence of these 
issues to primal scene fantasy, which can involve the child’s unconscious anxieties 
about his imagined intrusion into an unfamiliar and forbidden place and his 
witnessing a strange and disturbing scene, which, like the unassimilated immigrant 
in a foreign county, the child cannot comprehend.

The Issues of Power and Control

Following my dream report my therapist responded by focusing on the issues of 
“power and control” in the dream and my action of contacting the International 
Psychoanalytical Association. I had said to my therapist, “I can’t wait to get home to 
write up my thoughts about the dream.” My therapist chastised me. She said that I 
needed to discuss my thoughts with her and not withhold material from her. She 
said to me, “You’re only hurting yourself.” She said that my behavior — namely, 
trying “to be my own analyst” — was about power and control. I can’t disagree that 
an element in my relationship with my therapist was about “power and control” — 
though my therapist failed to see the transference aspect of my struggles with her as 
they relate to the issue of autonomy as it concerned my early relationship with my 
mother.

Are Erik Erikson’s observations about autonomy pertinent to understanding the 
power issues between my therapist and me? Erikson proposed a childhood 
developmental stage that centered on a conflict in the child and his mother relating 
to Autonomy vs. Shame and Doubt. Autonomy versus shame and doubt is the second 
stage of Erikson’s stages of psychosocial development. This stage occurs between the 
ages of 18 months to approximately 3 years. According to Erikson, children at this 
stage are focused on developing a sense of personal control over physical skills and a 
sense of independence. Success in this stage will lead to the virtue of will. If children 
in this stage are encouraged and supported in their increased independence, they 
become more confident and secure in their own ability to survive in the world. If 
children are criticized, overly controlled, or not given the opportunity to assert 
themselves, they begin to feel inadequate in their ability to survive, and may then
become overly dependent upon others, lack self-esteem, and feel a sense of shame or doubt in their abilities.

It would have been useful for my therapist to see the transference implications of my struggles with her and how these struggles connected to my early conflicts with my mother — as well as power conflicts I experienced in the workplace.

But there is another issue. And that issue is my therapist’s reaction to me, depicting me as “withholding” clinical material from her. There is a tie in with something basic to Kleinian theory. Note that my therapist held herself out as a “Kleinian analyst.” In Klein’s view, when the infant feels that his mother is withholding her breast from the child, the infant experiences envy: The best way to understand envy is to see it as the angry feeling that another (person) possesses, and is withholding, or keeping to itself, something one desires for oneself. The other person is, at the same time, to be seen as the reliable source for what one desires, and seen as possessing and withholding and keeping for itself something that “I want.” Envy is the feeling of conflict that what one desires, and would normally be forthcoming, is being withheld. The envious impulse is to attach, or to spoil the very source that one originally relied upon. This impulse can become diabolically destructive and undermining, since it mobilizes such powerful defences – devaluation of the good object, or rigid idealization. The infant’s feeling of failed gratification is experienced as the breast withholding, or keeping for itself, the object of desire. Envy is therefore more basic than jealousy, and is one of the most primitive and fundamental of emotions. Hiles, D., “Envy, Jealousy, Greed: A Kleinian approach.”

Regardless of my own behaviors possibly rooted in power and control (autonomy) there is my therapist’s possible reaction of envy to my act of withholding clinical material at the session. What I am setting up here is a transference/countertransference paradigm that has possible applicability beyond the clinical dyad. I have experienced serious difficulties in the workplace that appeared to be grounded in workplace mobbing. Mobbing means bullying of an individual by a group, in any context, such as a family, peer group, school, workplace, neighborhood, community, or online. It occurs as emotional abuse in the workplace, such as "ganging up" by co-workers, subordinates, or superiors, to force someone out of the workplace through rumor, innuendo, intimidation, humiliation, discrediting, and isolation. (Incidentally, perhaps we might extend the concept of mobbing to Freud’s experience of being forced from Vienna by the Nazis.) Mobbing targets in the workplace are often people who threaten the organizational stasis; and, the most
common characteristics identified as reasons for being targeted are refusing to be subservient (note the issue of “power and control”), superior competence and skill, positive attitude and being liked, and honesty. Kernberg observes that persons at a high level autonomy in groups will be attacked vigorously by the group — and this is crucial — the affect underlying the attacks will be group envy: envy of the autonomous persons’ “thinking, individuality, and rationality.” Are there parallels between the power dynamics between me and my therapist in the clinical setting and the power dynamics between me and coworkers in the workplace? Does my autonomy trigger my therapist’s envy?

My apparent refusal to be subservient to my therapist calls to mind a narcissistically inaccessible patient described by Modell who rejected any interpretation that his analyst made. Modell ultimately pieced together the following picture. The patient had been the precocious child of an inadequate and incompetent mother. The patient’s survival tactic had been to ignore his mother’s faulty counsel and work out life’s difficulties on his own independent of his mother’s input. The patient as an adult brought this mindset into his work in analysis.
PATIENT: On the days I'm away from therapy I struggle with something. I feel tormented by our work. I don't understand it. I struggle with confusion. A while back I read some things that Dr. Caligor said in an interview where she talked about her psychoanalytic work. Eve Caligor is a psychoanalyst in New York. I sent her a copy of my book. You know, that book I wrote about my last therapist. So let me read you what Dr. Caligor said. Dr. Caligor talks about the importance of free association and regression. We don't do free association. You once criticized me for "getting lost in the woods" when I was associating. Dr. Caligor talks about the importance of allowing unconscious material to emerge. I don't know how you do that without free association and regression. You call your work analytical. But I don't see it. I don't see anything analytical about your work. I still think what you are doing is essentially supportive psychotherapy. That's what I think. Let me read you what she said:

*Psychoanalysis is a highly unstructured treatment, where the technique focuses on transference analysis. The patient’s job is to free associate and the interventions of the analyst focus on the analysis of resistance and, particularly, on the resistance to transference. Analysis is, in my mind, a focal treatment, because the focus is on the transference most of the time. So we teach our trainees basically to work with the transference. One can think of the entire treatment frame and technique in psychoanalysis as developed expressly to provoke “regression,” the emergence of unconscious mental processes, focused in the transference, in a patient who is very well defended against such regression and very rigid. And how do you get transference? With a borderline patient, you get too much transference. With a neurotic patient the transference does not emerge very readily. So to be able to work actively and consistently in the transference in the therapy of a neurotic patient you need frequency, long duration of treatment, the analysis of the resistance to transference by a therapist. Use of the couch and the relative inactivity of the therapist also facilitate the emergence of transference; the patient cannot use interpersonal cures to automatically correct transference-based distortions as s/he does in her usual interactions with others.*

I asked my therapist what she was doing to promote regression and transference. She said: "You are already showing signs of regression and transference." She proceeded to, in my opinion, depict my concerns about her work as defensive rather than allay my concerns in a professionally-appropriate way. She said that I was expelling and that I was showing signs of "pre-splitting" in my thinking. I had no idea what she meant by her use of the term "pre-splitting." She did not offer an explanation of how her technique with me addresses the fact that I am well-defended against regression and transference and that her conversational manner (lack of
analytic abstinence) and disdain for free association ("getting lost in the woods," as she calls it) is actually adverse to regression and transference. I would add that her repeated use of technical jargon (such as the arcane term "pre-splitting") is inappropriate. On a previous occasion, I complained to my therapist about her statement, "Your thinking is ideographic and not symbolic." I said that even a supervising analyst would have a problem with an analyst-in-training using technical jargon such as "ideographic." Instead of accepting my concern in a professional way, she said in a pique of anger: "You have no idea what a supervising analyst would say. You're not an analyst."

Significantly, my therapist told me that I was trying to make her feel in my interaction with her what I had felt in my relations with my parents, in effect, I was doing to her what my parents had done to me: I was making her the target of my projections.

And exactly "what was I doing to" my therapist? I simply compared her work with the professional work of an experienced and knowledgeable psychoanalyst, herself a training and supervising analyst. There was a persecutory quality about my therapist's response to my opening statements: in her view, I was doing something to her.

My therapist ignored the important statements I made at the beginning of the hour about my emotional distress, my feelings of confusion, and what I called feelings of "torment." She viewed my comments only as an act of aggression against her rather than seeing my comments as carrying the following implicit message: "I am uncomfortable with your work. I have feelings of distress about our work. I believe, and Dr. Caligor's comments confirm, that there are other mainstream analytic techniques that I would feel more comfortable with." My therapist was blind to my distress, the psychoanalytical meaning of that distress, and the psychological reasons why I believed that a more classically analytical approach would be more satisfying for me. She failed to explore the transference implications of my behavior and its relation to introjective pathology in which "identification with the aggressor" is prominent. The therapist's statement, "You are trying to make me feel the way your parents made you feel" suggests identification with the aggressor, but my therapist did not explore that. See, Blatt, S.J. "Levels of Object Representation in Anaclitic and Introjective Depression" (in introjective depression the major defense, rather than denial, is introjection or identification with the aggressor, with a proclivity to assume responsibility and blame and to be harsh and critical toward the self).

I note, incidentally, that envy might account for my therapist's lack of empathy for my emotional distress in situations where I talk about my dissatisfaction with her.
work. Neurological research demonstrates that neural pathways for empathy are blocked in the brains of test subjects when they are shown pictures of higher status persons in distressing situations. Researchers think reduced empathy toward superior people is linked to how they make us feel bad about ourselves. Feng, C., et al., “Social Hierarchy Modulates Neural Responses of Empathy for Pain.” I offer the tentative thought: perhaps my therapist's feeling at this session that I was simply criticizing her aroused her envy, which blocked her ability to process my distress. She shows a pattern of framing my legitimate concerns about her work as an attack on her and redirects the discussion to her own feelings of distress when I question the value of her therapy technique.

My contemporaneous notes record the following exchange that took place during a session in October 2019. In the following text, note that my therapist ignores the emotional distress I express about her work; redirects the discussion to her own distress (“You are mean to me” and “You have a mean streak”); then proceeds to displace our dyadic therapy relationship onto my earlier interactions in a hostile workplace environment and seems to identify with coworkers who harassed me, possibly out of envy. At the present session (January 23) I read to the therapist Dr. Caligor's description of her therapy technique. At the earlier October 2019 session I opened the session by reading from a text by Sidney Blatt, M.D. about introjective patients.

The text reads:

Patient enters the therapist’s office carrying a book. It is a copy of the Psychoanalytic Study of the Child that includes a paper by Sidney Blatt that discusses anaclitic and introjective pathology. The paper is titled, “Levels of Object Representation in Anaclitic and Introjective Depression.”

Patient: I wonder what we are doing here. To me, you seem very interpersonally oriented in your work. And I wonder if that addresses my problems. You know, I struggle with issues that are not specifically interpersonal. I am so self-critical. It goes on all the time in my head. It never stops. I am a perfectionist. I am obsessed with performance and achievement. It was important to me to write my books. I look on that as an achievement. I don’t think about social relations. About doing social stuff. I am preoccupied with my inner world. And I don’t think your work addresses that. Everything here relates to me and other people. I remember back in June talking about my sense of elation about the upcoming summer solstice and you said, “Perhaps you are concerned about the length of our sessions. You talk about the solstice because you would like your sessions to be longer.” And I said, “What I was
thinking about was the idea of time standing still – and the idea of the Faustian moment, the Augenblick [my therapist knows some German] — a moment of bliss that would last forever.” I didn’t think my comments about the solstice related to you and me. I’m always thinking about me, not about you and me. I don’t see the world in those terms. Those relational terms. With me everything centers on my inner world. I was reading a paper by Sidney Blatt. He talks about anaclitic and introjective personalities. Based on his description I think I have a classic introjective personality. Let me read you just one paragraph. It’s the first paragraph of a section that talks about introjective personalities. That’s all I’ll read. I don’t think we ever touch on the things that he talks about. The things that he talks about are the things that relate to me specifically, I think. These particular psychological issues. Here, this is what he said:

Patient proceeds to read the paragraph and becomes angry as he points out every issue that he feels the therapist has not addressed in the therapy. The patient offers an angry and detailed lecture, based on psychoanalytic theory, concerning the therapist’s work. He seems determined to make her feel incompetent.

The therapist responds angrily. She proceeds to talk about how the patient picks fights with her, how he has been mean to her, how he wants to have his own way, how he acts as if he is the only person in the room. There is a personal quality to the therapist’s angry comments. She does not address how the patient’s presentation relates back to his introjective pathology: namely, the patient’s projection of angry internal objects onto the therapist. The therapist does not address the patient’s obvious feelings of frustration about the therapist’s technique and theoretical orientation and his feeling that the therapist seems determined to force an object relations orientation onto him rooted in Klein – Betty Joseph – and Bion that the patient feels does not address his needs. The back-story is that the patient was seeing the therapist twice per week and had several times asked to see her only once per week. The therapist repeatedly insisted that the patient see her twice a week and devalued him when he requested a reduction in scheduled
hours. “Your previous therapist said you were a freak,” she said. “Didn’t you tell me he said you were a freak?” [note the displacement]

The therapist proceeds to make an attempt at a transference interpretation as follows–

THERAPIST: The way you were mean to me probably accounts for why you had problems with your coworkers.

In fact, the patient was an outstanding employee who was a target of workplace mobbing. His supervisor was a known racist. The employer admitted in litigation that there was evidence of antisemitism in the supervisor’s department. The mobbing literature cites traits found in many mobbing victims that accounts for their interpersonal difficulties.

These traits appear to apply to the patient: “Those targeted are often people who threaten the organizational stasis; and, the most common characteristics identified as reasons for being targeted are refusing to be subservient (58%), superior competence and skill (56%), positive attitude and being liked (49%), and honesty (46%) (Namie & Namie).” Sloan, L.M., et al., “A Story to Tell: Bullying and Mobbing in the Workplace.” Adams and Field believe that mobbing is typically found in work environments that have poorly organized production or working methods and incapable or inattentive management and that mobbing victims are usually “exceptional individuals who demonstrated intelligence, competence, creativity, integrity, accomplishment and dedication.” The patient had been by described by his employer as being “as close to the perfect employee as it is possible to get” and an individual who “inspired his coworkers.”

[the quoted text concludes:]

It is striking that the “transference” issue here is actually a counter-transference issue. The therapist, in her anger, identifies with those persons in the patient’s environment who had abused him. In this way the therapist rationalizes her anger toward the patient and rationalizes the behavior of his coworkers toward him. The
The therapist also failed to address the authority struggle here. Previously, she stated several times, “I am the analyst,” seeming to assert her authority but she has never bothered to explore the psychological meaning of the patient’s “refusal to be subservient” in the workplace and in therapy.

[end of quoted text about October 2019 session]

In yet another therapy session that took place on August 2, 2019 a parallel situation arose. Recall that at the present session (January 23, 2020) my therapist said, “You are trying to make me feel what you felt in your relations with your parents.” At the earlier August 2019 session my contemporaneous notes record that she said, “You did to your [previous] therapist what your employer did to you.” At that session I told my therapist that I had filed a complaint against my previous therapist with the Social Work Disciplinary Board. My therapist refused to read said complaint and I never talked about the reason for the complaint. The therapist directed her attention only to the process issue of “complaining about a therapist” rather than consider the content or merits of the complaint, which didn’t seem to interest her.

In the following contemporaneous notes I compare my therapist’s conduct to a recognized dynamic found in antisemitism. My purpose was not to expose an antisemitic bias by my therapist. Rather, my aim was to show that the therapist’s statement “You did to your [previous] therapist what your employer did to you” parallels a recognized neurotic dynamic and that that neurotic dynamic might in fact be an emotionally significant unconscious schema for the therapist that she projects onto me. My aim was to hint at a possible countertransference interpretation of the therapist’s statement, “You did to your [previous] therapist what your employer did to you.”

The text describing the August 2, 2019 session reads:

My therapist said to me, “You did to your [previous] therapist what your employer did to you.” This statement is an example of the therapist confabulating facts to allow her to fit these “facts” into her internal schema of me as an aggressive (“violent”) bad object. The fact is that my employer lied about the reasons for my job
termination and later filed an apparently perjured Response with a District agency alleging that it had determined that I was mentally unfit for employment and that I posed a direct threat in the workplace (the employer alleged that I was “potentially violent”). Perjury is a criminal act; it is a felony. The allegations I made in the ethics complaint against my last therapist were factual. In point of fact, I did not do to my therapist what my employer did to me. My employer lied about me but I did not lie about my previous therapist. What is striking is that the dynamic that my therapist offered (“You did to your therapist what your employer did to you”) is classic antisemitism. One antisemitic stereotype is that Jews are hypocrites: “They complain about other people, but they act the same way.” See, Grunberger, B. “The Anti-Semite and the Oedipal Conflict.” Grunberger writes: “The Jew represents the father, and from that perspective we can understand the various aspects of the anti-Semite’s behavior. We understand, for example, why the Jew excites so much attention, why his conduct must be perfect, and why his slightest moral weakness is exaggerated by the anti-Semite who would remain utterly indifferent, even approving or amused before the most shameful actions and moral turpitudes perpetrated by non-Jews. He reminds us of the adolescent at the climax of his Oedipus conflict, forgiving nothing in his parents and on the look-out for the slightest fault in their moral conduct, and particularly in respect to the father, as though he would say: ‘Look at yourself, you who preach morals to me and wish to criticize me at every moment.’” “The Anti-Semite and the Oedipal Conflict (emphasis added).” The observation that “the Jew represents the father” might provide a window into my therapist’s countertransference (emphasis added). Is it possible that she sees me as her father? I wonder about my therapist’s repeated — and factually unsupported — references to me committing “acts of violence” against others. Are the therapist’s factually distorted attributions to me related to the therapist’s own primal scene concerns: “Daddy, I know what you do to mommy in your bedroom. You commit acts of violence against mommy!”
[end of quoted text of August 2, 2019 session]

At three sessions my therapist has used a variation of the neurotic schema, “Look at yourself, you who preach morals to me and wish to criticize me at every moment.”

1. You complain about the way your parents treated you, but you treat me the same way (January 23, 2020);

2. You complain about your employer, but you treated your previous therapist the same way
3. You complain about your coworkers, but you treat me the same way (October 2019).

1. Possible Transference/Countertransference Enactment
I served as the identified patient in my family; family members designated me the black sheep. The identified patient is the person in a dysfunctional family who was unconsciously, or sometimes consciously, selected to lay blame upon to draw attention away from the family's true inner conflicts, true problem behaviors, and their perpetrators. The identified patient is a diversion and a scapegoat. This person is "the split-off" false carrier of a breakdown in the entire family system, which may be a transgenerational disturbance or trauma. Rudnytsky, P.L., Reading Psychoanalysis.
I have had serious interpersonal difficulties in two places of employment where I served a scapegoat role. The term Identified Patient is also used in the context of organizational management, in circumstances where an individual becomes the carrier of a group problem where, through projective identification, unwanted parts of the "group-as-a-whole" are split off and projected into a scapegoat. Individual history can prime an individual to receive a certain type of group projection. Individuals, for example, who have been designated as black sheep in families may be predisposed to become scapegoats in groups. Hazell, C., Imaginary Groups.
Might we conjecture that I bring Identified Patient dynamics into the dyadic therapy relationship where transference-countertransference enactment recapitulates early conflicts in my family, just as, perhaps, I brought Identified Patient dynamics into the workplace?
In carrying out transferential enactments, clients assign to themselves and their therapist roles specific to past experiences that have remained conflictual and thus carry heightened affect. They “intend” to play a part and have their therapist play a related one for various reasons, some of which might overlap. They are usually revisiting the past in order to have it turn out better. Where the therapist unconsciously colludes with the patient’s enactment or unconscious life-script, a complementary transference-countertransference arises. Schaeffer, J.A., “Double Edged Swords: Improving Therapy Through Interpretation.”
Countertransference enactment is often a matter of therapists’ participating in the acting-out of clients’ transference. Therapists unconsciously collude with clients in mutual projective identification organized primarily around clients’ unresolved
conflicts. *Id.* Countertransference enactment can also be a matter of therapists’ own unresolved conflicts. Those with narcissistic conflicts, for instance, might repeatedly insist that they are right. *Id.* I once said to my therapist: "You state your comments with too much certainty." She replied: "Of course I speak with certainty. I’m a psychoanalyst!" Those with aggressive conflicts might act belligerently. *Id.* My therapist has several times repeated comments of a previous therapist: "He said you were a freak. He said you were a buffoon." My therapist became abusive when I told her I wanted to change my schedule from twice per week to once per week sessions; I recall her saying, “You want to fuck everything up.” Those with unresolved security conflicts might be dogmatic. *Id.* My therapist is dogmatic in emphasizing here-and-now transference interpretation regardless of my therapeutic best interests and research that indicates that the use of transference interpretation needs to be tailored to the needs of individual patients. See, e.g., Levy, K. and Scala, J.W., "Transference, Transference Interpretations, and Transference-Focused Psychotherapies." Cf., Werbart, A., "Matching Patient and Therapist Anaclitic–Introjective Personality Configurations Matters for Psychotherapy Outcomes."

At other times, countertransference enactment can be a matter of therapists attempting to counteract their own weaknesses. Those who are indecisive, for instance, may exaggerate their open-mindedness. *Id.* When I complained that my therapist responded with hostility when I criticized her, she replied: "I welcome criticism." Yet, as we see at this session when I compared her professional work with that of Eve Caligor, M.D., she attributed my comments to defenses and character pathology notwithstanding the fact that my critique was a legitimate request that my therapist explain and justify her conversational manner, lack of analytic abstinence, and her hostility to free association (or as my therapist has called it, "getting lost in the woods"). On one occasion my therapist said I was being "mean" to her and that I had a "mean streak" after I raised questions about her work based on Sidney Blatt’s research on introjective personalities. When I criticize my therapist she invariably focuses exclusively on my act of criticism (a process issue) as if she were intentionally avoiding the content of my criticism, which is almost always based on published research about therapeutic technique.

Thomas Ogden thinks of countertransference enactment as a powerful non-verbal “interpretation” being unconsciously conveyed to clients. *Id.* Countertransference enactment has been identified as an unconscious means of either indulging or punishing clients. Therapists unwittingly indulge clients by “caressing” them with words in order to quiet their own negative feelings. *Id.* At a
recent session, my therapist praised my "creativity," told me that I was a "worthwhile person," and that I worked hard at trying to understand myself. My therapist once said, "I like your writing style," praise that now seems shallow given that she now often refuses my letters. On one occasion when I said that I had accomplished little in life (I have two law degrees, but never practiced law and have lived on disability for much of my adult life), she replied: "You undervalue your accomplishments."

Therapists may speak in soft tones or assure clients that all things are passing. Id. Not infrequently, my therapist offers her comments in a nearly inaudible voice; I find myself having to ask her to repeat what she has said. Similarly, therapists try to divert clients from painful countertransference-causing conflictual material by directing attention to non-countertransferential material. Id.

My basic point is that there is substantial reason for my therapist to think about how I bring Identified Patient dynamics into the therapy relationship by inducing her, through my projective identification, to repeat early relations in my family in which I served as a carrier for the warded off mental contents of family members. Melanie Klein's thinking about the repetition compulsion might be read to clarify the role of projective identification in transference-countertransference enactment, specifically as it relates to the patient inducing the therapist to play a role in the patient's life script. Might the following dynamics help explain the process whereby a patient with Identified Patient dynamics induces the therapist to recapitulate the roles played by family members in a dysfunctional family in which the patient served as a container for family members' warded off mental contents? 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
The Kleinian analyst Betty Joseph writes that analysis of the therapist's countertransference is vital. “Countertransference, the feelings aroused in the analyst, like transference itself, was originally seen as an obstacle to the analytic work, but now, used in this broader sense, we would see it, too, no longer as an obstacle, but as an essential tool of the analytic process.” Joseph, B., “Transference: The Total Situation.”

My therapist's consideration of her countertransference would require her to have insight into her own unconscious mental life, her possible use of projective identification, and her unconscious scapegoating behaviors. But that would require the therapist's integrity and technical competence. Note that my therapist has not completed her analytic training. Note also that at this session there was a suggestion of the therapist's lack of professional integrity. She attributed my legitimate criticism of her work to my defensiveness despite the fact that the literature recognizes that there is a reality basis to transference - "that some of it is reality based." Levy, K. and Scala, J.W., "Transference, Transference Interpretations, and Transference-Focused Psychotherapies." My therapist consistently refuses to acknowledge the possibility that her technique does not match my therapy needs and consistently attributes my critiques to defensiveness and character pathology.

For example, research shows that the use of free association is important in the psychodynamic treatment of introjective personalities. Blatt and Shahar point to the fact that modalities that eschew free association have been found to be effective with anaclitic patients because they provide a supportive therapeutic context that contains the associative activities and maladaptive interpersonal schemas of these more affectively labile, emotionally overwhelmed, and vulnerable patients. Free association, by contrast, facilitates the development of adaptive interpersonal schemas and the decrease of maladaptive ones in introjective patients because the explorations and interpretations based on free association may more effectively engage these more distant, well-defended, and interpersonally isolated individuals. The value of free association is consistent with clinical observations and expectations, as well as with recent findings by Fertuck et al. that therapeutic progress in seriously disturbed treatment-resistant anaclitic inpatients was significantly associated with a reduction in referential activity, while progress in introjective patients was significantly associated with its increase. Blatt, S.J. and Shahar, G., "Psychoanalysis—with Whom, for What, and How? Comparisons with Psychotherapy." How can my therapist justify her non-use of free association and at the same time adamantly hold the position that my criticism of her work is simply
rooted in defensiveness and character pathology? Does my therapist's response to my criticisms suggest her lack of professional integrity and limitations in her technical competence?

Malcolm argues that Merton Gill’s overemphasis on here-and-now interpretation of the transference leaves little room for free association and psychoanalytic exploration of the unconscious. She says Gill doesn’t allow enough silence: “The analysis remains frozen in the present.” Malcolm, J. “The Patient Is Always Right.”

Additional note: The possibility of transference-countertransference enactment in my treatment, in which I induce my therapist to play a role in my life script, might make analytic abstinence all the more advisable. Eric Berne, M.D. saw analytic frustration as a means of avoiding playing a part in the patient's life script. Berne, E., *What Do You Say After You Say Hello?* How does my therapist justify her disinterest in the value of analytic abstinence in working persons with my personality problems?

2. Might Injudicious Use of Transference Interpretation Promote Guilt in an Introjective Patient? – Might Injudicious Use of Transference Interpretation Exacerbate Resistance in a Patient with a Strong Fear of Engulfment?

By definition the introjective person employs the defense of identification with the aggressor by introjecting or identifying with the aggressor, with a proclivity to assume responsibility and blame and to be harsh and critical toward the self. I am concerned about my therapist's use of transference interpretations, some of which she terms "poignant interpretations," such as, "your behavior was violent," "your behavior was an act of violence," "you are expelling," "you devalue me," "you are mean to me," "you fragment things," "your thinking is idiographic and not symbolic," "you are engaging in pre-splitting," "you don't want me to have my own mind," "you don't want me to have my own thoughts," "I feel you suck the air out of the room," "you're not the only person in the room," "you are attacking links," "you are destroying knowledge," etc. Might inexpert transference interpretations promote guilt or self-criticism in a pathologically introjective patient?

I am concerned about the adverse effects of transference interpretations that are based on my therapist's intuition rather than on the hard evidence of my material. I once told my therapist that it seemed that some of her observations about me were based on insubstantial material. I pointed out that a previous therapist, Stanley R. Palombo, M.D., an experienced psychoanalyst who wrote a book about psychoanalytic technique (*The Emergent Ego: Complexity and Coevolution in the Psychoanalytic Process*), seemed to hold off in offering an interpretation until an opportune time and until he had confidence in the interpretation's reliability. My therapist replied: "Some analysts do that. I don't. I'm not concerned with accuracy."
I have the impression my therapist offers comments willy-nilly when an idea happens to pop into her head and I assume many of her comments are not based squarely on my clinical material but on the fact that, in her mind, the interpretation just happens to "feel right." I am not in a position to judge the advisability of my therapist's technique, which might be legitimate. I read that Kleinian analysts—my therapist has called herself a Kleinian—are not concerned with analyst verbosity or the timing of interventions. But I question the advisability of my therapist's technique in the treatment of an introjective patient who struggles with a tendency to introject negative evaluations. Levy and Scala cite evidence that transference interpretation should be tailored to the patient's personality. Thus, for example, "[f]or those with more interpersonal difficulties or cluster C problems [anxious, fearful, dependent], high levels of transference interpretations may result in poorer outcome or less reduction in interpersonal problems, particularly for those with weaker alliance." Werbart writes about “psychoanalytic psychotherapy”: "Different patients require not only different treatments but also different therapeutic relationships . . . . These findings suggest the importance of the therapists’ early adjusting their orientation on relatedness [anaclitic] or self-definition [introjective] to their patients’ predominant personality configuration in order to enhance treatment outcomes." Werbart, A., "Matching Patient and Therapist Anaclitic–Introjective Personality Configurations Matters for Psychotherapy Outcomes."

Even Betty Joseph, a Kleinian analyst, seems to suggest that transference interpretation needs to be tailored to the patient's individualized personality. “...that movement and change is an essential aspect of transference—so that no interpretation can be seen as a pure interpretation or explanation but must resonate in the patient in a way which is specific to him and his way of functioning; that the level at which a patient is functioning at any given moment and the nature of his anxieties can best be gauged by trying to be aware of how the transference is actively being used; that shifts that become visible in the transference are an essential part of what should eventually lead to real psychic change.” Joseph, B., “Transference—The Total Situation.”

Betty Joseph’s comments notwithstanding, might Kleinian technique in certain respects be counter-therapeutic for some types of patients? Werbart, though not referring specifically to transference interpretation, states that introjective pathology responds best to classical analytic technique: "The introjective configuration is connected with excessive demands for achievement and perfectionism, and with attachment avoidance unlike the anaclitic configuration which is connected with difficulties in close relationships and attachment anxiety."
Introjective depression, based on the sense that “I am a failure,” responds to classical psychoanalysis, with the therapist as a listener, helping to elicit growth in an independent sense of self. Anaclitic depression, based on the feeling that “I am not worthy of love,” is effectively treated by a more assertive therapist, guiding the formation of relationships. Werbart, A. "Matching Patient and Therapist Anaclitic–Introjective Personality Configurations Matters for Psychotherapy Outcomes." Blatt and Shahar's conclusions about the value of classical analysis in the treatment of introjective patients might, perhaps, carry implications about the advisability of classical transference interpretation in such individuals. The authors state: "[Classical psychoanalysis] was found to contribute significantly to the development of adaptive interpersonal capacities and to the reduction of maladaptive interpersonal tendencies, especially with more ruminative, self-reflective, introjective patients, possibly by extending their associative capacities. [Therapies that eschew free association], by contrast, [were] effective only in reducing maladaptive interpersonal tendencies and only with dependent, unreflective, more affectively labile anaclitic patients, possibly by containing or limiting their associative capacities."

The following text raises a concern in my mind that the injudicious use of transference interpretation might promote guilt in introjective patients. The passage perhaps also raises a question about the value to an introjective patient of a therapist's focus on psychotic anxieties grounded in her understanding of Klein and Bion rather than on the higher level ego functions associated with the relative maturity of introjective patients.

Blatt writes: "In introjective depression there is a higher level of ego development [than in anaclitic depression], and object relations are at the later stages of separation and individuation. The major defense, rather than denial, is introjection or identification with the aggressor, with a proclivity to assume responsibility and blame and to be harsh and critical toward the self. Object relations extend beyond need satisfaction, and the cathexis of and involvement with the object persist independent of frustration and gratification. There are concerns about receiving love and approval from the object, and there are also concerns about the object’s response to and acceptance of one’s feelings of love for the object. The relationship is highly ambivalent, and the person is unable to resolve and integrate the contradictory feelings. There are attempts to retain the object and its potential love and approval through introjection, and the struggles which originally were between the person and the ambivalently loved object come to exist primarily within the person. The representations of the object are more differentiated, but are based on repetitive, drive-laden interactions with the object and on distorted, exaggerated, and
contradictory part properties and features of the object. Since these representations are usually based on the ambivalent, hostile, and aggressive aspects of the object relationship, the internalizations result in feelings of doubt, self-criticism, and guilt. The continual negative self-judgments and guilt, as well as the exaggerated and overstated representations, serve to maintain contact with the object in a vivid and hypercathected way. Object and self-representations are at a somewhat higher developmental level in introjective depression [than in anaclitic depression], as indicated by the fact that guilt requires some sense of self, a capacity to be self-reflective, and some appreciation for sequences of causality, both in assuming responsibility for an act and in considering alternate modes of atonement and reparation. Blatt, S.J. "Levels of Object Representation in Anaclitic and Introjective Depression."

Engulfment Fears
I am an introjective patient with strong fears of maternal engulfment. Might a therapy technique that reduces virtually everything a patient says to transference and that ignores extra transference conflict promote rather than lessen engulfment fears and negative transference in an introjective patient? At a session in mid-June I talked about my fascination with the summer solstice. My therapist intervened: "Maybe you are really talking about your desire that your sessions be longer." In fact, I can trace my interest in the summer solstice at least back to age 18 when I was in college. In the spring of 1972 I took an English course in which we read Fitzgerald's novel, The Great Gatsby. I had underlined and inserted an asterisk next to the text: "Do you always watch for the longest day of the year and then miss it? I always watch for the longest day in the year and then miss it." I loved The Great Gatsby; I was enthralled by Nick Carraway's idealization of his friend, Jay Gatsby, about whom Carraway writes: "If personality is an unbroken series of successful gestures, then there was something gorgeous about him, some heightened sensitivity to the promises of life, as if he were related to one of those intricate machines that register earthquakes ten thousand miles away." In some sense, Gatsby was Carraway's imagined twin. See section 4, below.

Further, I am concerned about my therapist's creation of a double-bind situation. A double bind is a dilemma in communication in which an individual receives two or more conflicting messages, with one negating the other. In some circumstances (particularly families and relationships) this might be emotionally distressing. This creates a situation in which a successful response to one message results in a failed response to the other (and vice versa), so that the person will automatically be wrong regardless of response. The double bind occurs when the person cannot confront the
inherent dilemma, and therefore can neither resolve it nor opt out of the situation. A double bind situation arises in my therapy, in my opinion, from my therapist's (possibly defensive) need (see section 3, below), on the one hand, to inflexibly use a transference interpretation technique that inescapably promotes my engulfment fears and, at the same time, her need to comply with the demands of her narcissism that require her to censor the expression of negative feelings about her. Thus, when I complained, "I feel you suck the air out of the room," she countered unproductively: "I feel that you suck the air out of the room." When I state negative feelings about her she almost invariably frames my comments as projections rather than explore the extra transferential sources of my distress: that is, as a revival of a past conflict. I have two options which cancel each other out, namely, silently endure my distressed feelings of engulfment, or speak of them and risk being accused of engaging in an unfair attack ("You are doing to me what your parents did to you" or "you did to your last therapist what your employer did to you," "you are being mean to me," or "you devalue me," or "you are attacking links," or "you are destroying knowledge," etc.).

3. A Therapist's Possible Defensive Use of Transference Interpretation
Might an anaclitic therapist fail to appreciate the limits of transference interpretation because of her psychological struggles centering on issues of relatedness? The legitimacy of my therapist’s technique notwithstanding, I am struck by the fact that at times my therapist's technique seems indistinguishable from the confession of a dependent, self-absorbed patient: "I need you to think about me and only me. I need to be the center of your universe. I need to see myself in everything you say because I need to believe that I am always in your thoughts." I see an almost fetishistic or ritualistic quality to my therapist's transference work. She seems almost to feel viscerally threatened when I question her transference work, as if it satisfies some deeply personal and defensive need. She is unable to acknowledge the drawbacks of the indiscriminate use of transference interpretation as well as the requirement that transference interpretation must, as Betty Joseph states, resonate in the patient in a way which is specific to him and his way of functioning. What is the appropriate transference interpretation of a patient's criticism in a case where the patient shows a low level of internalization, that is, where the struggles between the person and the ambivalently loved object continue to exist primarily outside the person, versus the appropriate transference interpretation of a patient's criticism in a case where the patient shows a high level of internalization, that is, where the struggles which originally were between the person and the ambivalently loved object come to exist primarily within the person? Is a reliance on
"here and now" interpretations (modeled on the work of analysts like Betty Joseph) optimally beneficial for an introjective patient? Or might classical transference interpretation be optimally beneficial? Is extra transference interpretation optimally beneficial for introjectives or is it not?

At least one authority supports the view that a therapist's concentration on “here-and-now” transference interpretation can be defensive. Thomas Szasz points out that transference analysis privileges the analyst’s view of reality and may involve judgments about the patient’s view of reality, which may or may not be shared by the patient. Furthermore, analysis of transference can be a defensive maneuver for the therapist, protecting her from the impact of the patient’s personality. Szasz, T., “The concept of Transference.”

My therapist is oblivious to the requirement that therapy be evidence-based, and I have the sense that she has chosen precisely that type of transference work that allows her to rationalize her defensive needs, which seem to involve relatedness issues, just as she makes transference interpretations that will preserve her narcissistic integrity. I conjecture that in her transference work she has found an adaptive niche for her defensive relatedness needs even as she has found in the psychoanalytic lexicon a veritable and unassailable “morality of distinction.” See, Horney, K., New Ways in Psychoanalysis (quoting Nietzsche).

Klein wrote that an analyst must tackle a patient's negative transference first (in my case, the expression of criticism), before progress can be made in the development of a positive transference. And I might add that in order to tolerate and analyze a patient's negative transference calls for an analyst who truly thinks well enough of herself and her own goodness that she is not dependent upon the goodness and cooperativeness of the patient in order for such a positive self-perception to be confirmed, and in order for her to continue to function analytically. I am not at all convinced that my therapist truly thinks well of herself. When a patient says, “I feel you suck the air out of the room,” and the therapist responds, “I feel you suck the air out of the room,” that therapist does not think well of herself.


Applying a Kleinian framework, my critical attitude toward my therapist can be seen as persecutory; that seems obvious. Applying a Bionian schema we might interpret my critical attitude as “an envious attack on her thinking or on the links that might render her communications meaningful and relevant.”

But can my insistent criticism of my therapist be viewed also as an expression of depressive anxiety?
Twinship and the Idealized Good Object
To what extent is my dissatisfaction with my therapist related to my perception that she is unable to serve as an object who might be able to understand and transform my inchoate experiences? Is it possible that the affect underlying my criticism of her is loneliness? Is my preoccupation with psychoanalytical exploration of my personality through free association linked to my desire to be understood by the good object, a longing to regain the “un-understood and split off” parts of myself, the idealized parts?

Klein writes: “The longing to understand oneself is also bound up with the need to be understood by the internalized good object. One expression of this longing is the universal phantasy of having a twin . . . . This twin figure [] represents those un-understood and split off parts which the individual is longing to regain, in the hope of achieving wholeness and complete understanding; they are sometimes felt to be the ideal parts. At other times the twin also represents an entirely reliable, in fact, idealized internal object.” Klein, M., “On the Sense of Loneliness.”

The Sense of Awe
I often succumb to intense feelings of awe. A sense of awe is a prominent feature of my dreams. Thus in one dream: Beethoven and I are alone in a room. We talk about music. I feel awe, enthrallment and narcissistic elation talking to Beethoven. In another dream: I find myself in Greensboro, North Carolina [and] I am filled with feelings of awe . . .

Bion provides an avenue to understanding my feelings of awe as they relate to my critical attitude toward my therapist. We need to ask: Does my critical attitude toward my therapist—my disappointment in her and my hostility toward her—represent a struggle centering on my search for “an outlet for feelings of reverence and awe?”

The following is an excerpt from a paper by Judith L, Mitrani, Ph.D.: “Unbearable Ecstasy, Reverence and Awe, and the Perpetuation of an ‘Aesthetic Conflict’.” Dr. Mitrani is Training and Supervising analyst of The Psychoanalytic Center of California in Los Angeles.

“The psychoanalyst Wilfred Bion describes a patient whose attacks on him in analysis, which centered on the patient’s feelings of disappointment and hostility, did not constitute an attack on the ‘good breast’ or the analyst’s good interpretations. Neither did Bion seem to see the patient’s fragmented presentation as the result of an envious attack on thinking or on the links that might have rendered his communications meaningful and relevant. Instead, Bion appears to conclude that his patient was attempting to have an experience of an object who
might be able to understand and transform the inchoate experiences of the as-yet-unintegrated-baby-he and was therefore seeking the realization of his preconception of an object who could contain these experiences as well as his innate capacity for love, reverence, and awe.

In a paper read at a scientific meeting of the Los Angeles Psychoanalytic Society in 1967, Bion described an encounter with one patient who came to him after a previous analysis from which he had benefited, but with which he was nonetheless dissatisfied. At first Bion expected to find greed at the bottom of this patient’s distress, but it soon became clear to him that there was something else going on. Bion described his patient’s outpourings, which were so fragmented ‘that they would have required an omniscient analyst to sort out and make sense of.’ Bion’s interpretations were either labeled ‘brilliant’ or they were met with extreme disappointment and hostility to the point of depression. He finally concluded that: There is a great difference between idealization of a parent because the child is in despair, and idealization because the child is in search of an outlet for feelings of reverence and awe. In the latter instance the problem centers on frustration and the inability to tolerate frustration of a fundamental part of a particular patient’s make-up. This is likely to happen if the patient is capable of love and admiration to an outstanding degree; in the former instance the patient may have no particular capacity for affection but a great greed to be its recipient. The answer to the question — which is it? — will not be found in any textbook but only in the process of psycho-analysis itself.

In his customary style, Bion avoids saturating his concepts, leaving them somewhat ambiguous, and thus allowing us the freedom to use our own capacity for ‘imaginative conjecture’ to fill in the blanks, so to speak. I will yield to the temptation to do so with the understanding that the reader may draw his or her own conclusions, which may very well differ from my own. I think Bion seems to be saying that, in this instance, he had met with a patient for whom Melanie Klein’s theory of envy did not apply. Indeed he seems to be making it clear that he did not see his patient’s disappointment and hostility as constituting an attack on the good breast or the analyst’s good interpretations. Neither did he seem to see the patient’s fragmented presentation as the result of an envious attack on thinking or on the links that might have rendered his communications meaningful and relevant. Instead, Bion appears to conclude that his patient was attempting to have an experience of an object who might be able to understand and transform the inchoate experiences of the as-yet unintegrated-baby-he and was therefore seeking the realization of his preconception of an object who can contain these experiences as well as his innate capacity for love, reverence, and awe. I would put forward here that
the containing capacity, initially found and felt to be located in this type of external object — when introjected — leads to the development of an internal object capable of sustaining and bearing feelings of ecstasy and love; an object that might form the basis of the patient’s own self-esteem. This aim certainly calls for an analyst who truly thinks well enough of himself and his own goodness that he is not dependent upon the goodness and cooperativeness of the patient in order for such a positive self-perception to be confirmed, and in order for him to continue to function analytically.”

A Desperate Struggle Centered on Restoring the Internalized Good Object

Is my critical attitude toward my therapist based on my sense of her as a revival of my infantile sense of my mother as having been reduced to a state of dissolution resulting from my sadism: a struggle involving my imperative need to restore her to a state of wholeness? Am I trying to do away with the “bad bits” and restore the “good bits?” Am I attempting to perfect my therapist? Am I attempting to restore my therapist's wholeness? See, Klein, M., “A Contribution to the Psychogenesis of Manic-Depressive States.” See also, Searles, H.F., “The Patient as Therapist to his Analyst.”

Klein writes: “It seems to me that only when the [infant’s] ego has introjected the object as a whole and has established a better relationship to the external world and to real people is it able fully to realize the disaster created through its sadism and especially through its cannibalism, and to feel distressed about it. This distress is related not only to the past but to the present as well, since at this early stage of development the sadism is in full swing. It needs a fuller identification with the loved object, and a fuller recognition of its value, for the ego to become aware of the state of disintegration to which it has reduced and is continuing to reduce its loved object.

The ego finds itself confronted with the psychical fact that its loved objects are in a state of dissolution—in bits—and the despair, remorse and anxiety deriving from this recognition are at the bottom of numerous anxiety-situations. To quote only a few of them: There is anxiety how to put the bits together in the right way and at the right time; how to pick out the good bits and do away with the bad ones; how to bring the object to life when it has been put together; and there is the anxiety of being interfered with in this task by bad objects and by one’s own hatred, etc.

Anxiety-situations of this kind I have found to be at the bottom not only of depression, but of all inhibitions of work. The attempts to save the loved object, to repair and restore it, attempts which in the state of depression are coupled with despair, since the ego doubts its capacity to achieve this restoration, are determining factors for all sublimations and the whole of the ego-development. In this
connection I shall only mention the specific importance for sublimation of the bits to which the loved object has been reduced and the effort to put them together. It is a ‘perfect’ object which is in pieces; thus the effort to undo the state of disintegration to which it has been reduced presupposes the necessity to make it beautiful and ‘perfect’. The idea of perfection is, moreover, so compelling because it disproves the idea of disintegration.” Klein, M., “A Contribution to the Psychogenesis of Manic-Depressive States.”
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I opened the session by talking about my feelings of discomfort with my therapist. She told me that I reminded her of an analytic patient of the psychoanalyst Ron Britton.

The psychoanalytic encounter provides the patient with the disturbing experience of an individual who embodies the maternal and paternal capacities of containing and providing a perspective, someone who can ‘hold’ and ‘see’ him or her in time and in space. The internal capacities of the analyst and the external setting of the analytic session demonstrate the possibility of the integration of the parental qualities of containment and perspective to a patient who may not be comfortable with the idea of being held or being seen and perhaps unable to tolerate the possibility of those attributes being embodied in one person. This is graphically expressed by one of Britton’s patients, Miss A, who experienced his ability to commune with himself about her as a representation of the parental intercourse from which she was excluded (Britton, 1989). She shouts: ‘Stop that fucking thinking’, demonstrating her need to keep her parents apart, to prevent the mental catastrophe in which acknowledgment of their coming together would result. The catastrophe has already happened, of course, and it is an example of timeless and spaceless thinking that a refusal to acknowledge the parental union is phantasized as being a means to prevent it from taking place.

My therapist seemed to be saying that I was unable to accept her as a container for my anxieties.

Bion’s theory of containing originates from the idea that the infant projects into its mother feelings that are upsetting, fearsome, painful or in some other fashion, intolerable. The mother in turn feels the emotion herself, and is able not to react to it, but instead to contain it and give the child back the feeling in an adapted and contained form to the infant, so the child can repossess it and reintegrate the emotion as its own. "Holding and Containing—Winnicott."

Containment is crucial in a therapeutic context as a way of providing a safe place for the client to look at feelings that otherwise are likely to be experienced as overpowering and bewildering. The importance of this in the healing process cannot be underestimated. Individuals who have experienced extreme pain, fear, desertion and anger will often find it difficult to think; they may find it particularly difficult to think about their emotions, which can remain completely exempt from consciousness, and hence unavailable for reflection. Id.

Keep in mind that the analyst needs to distinguish the lower-level patient's inability to use the analyst as a container, that is, the patient's inability to permit the analyst to “see” him and to “hold” his primitive anxieties, versus the neurotic patient's higher level ego functioning that will feature neurotic resistance, resistance to transference, and ego defenses, such as repression,
which will prevent the patient's access to unconscious anxieties. An inexperienced analyst with a superficial understanding of Bion might very well naively mistake the banal presentation of the introjective patient who struggles with unconscious guilt for the more psychologically-undeveloped patient's inability to verbalize ("think about") overpowering and bewildering feelings. Freud describes the obstinate resistances of the guilt-ridden neurotic (in Kleinian terms, the patient struggling with "depressive anxiety") who is incapable of verbalizing (or "thinking about") his unconscious (unspeakable) distress. Freud writes: "The battle with the obstacle of an unconscious sense of guilt is not made easy for the analyst. Nothing can be done against it directly, and nothing indirectly but the slow procedure of unmasking its unconscious repressed roots, and of thus gradually changing it into a conscious sense of guilt. . . . . . .[A]s far as the patient is concerned [the] sense of guilt is dumb; it does not tell him he is guilty: he does not feel guilty, he simply feels ill. This sense of guilt [in Kleinian terms, "depressive anxiety"] expresses itself only as a resistance to recovery which is extremely difficult to overcome." Freud, S., "The Ego and the Id." The analytic narrative of one neurotic patient was described as "fifty minutes [of a] young man's halting, rambling soliloquy describing ordinary trivial events and expressing commonplace thoughts and feelings. It was like listening to a boring, self-absorbed acquaintance." Malcolm, J., Psychoanalysis: The Impossible Profession. It is revealing that the analyst (Hartvig Dahl, New York Psychoanalytic Institute) reported that this session—session no. 5 of a multi-year analysis—hadn't struck him as particularly significant at the time; only in retrospect, after the analysis was over, could he make out the session's prophetic character. This seemingly unimportant session foreshadowed, like the overture of an opera, the major themes of the ensuing multi-year analysis. A knowledgeable analyst capable of "loose, desire-less, undirected listening," will be able to decipher the implicit, or unconscious meaning of the neurotic patient's emotionally-bland report. While an amateurish analyst with a grandiose sense of her expertise in Bion might well conclude that a patient's abstruseness indicates ego enfeeblement, which precludes the patient's ability to use the analyst as a container for his psychotic anxieties.

Returning for a moment to Britton's patient who experienced the analyst's ability to commune with himself about the patient as a representation of parental sexual intercourse from which she was excluded, demonstrating her need to keep her parents apart, to prevent the mental catastrophe in which acknowledgment of their coming together would result. My therapist on occasion will say that I don't want to allow her to have her own mind, that I don't want to allow her to have her own thoughts in response to my criticisms about her talkativeness. She confuses my
justifiable concerns about her lack of analytic abstinence with, alternatively, psychic threats emanating from psychotic anxieties aroused by an imputed association of thinking with parental sexuality. It is believed that the child in paranoid-schizoid anxiety is threatened by the parents’ sexuality. “[In the paranoid-schizoid position, the] child is caught up in the primal scene with a frightful sense of bewilderment, unable to make sense of the experience because of his or her limited capacity for observation or reflection. When the primal scene is experienced and perceived in the depressive mode of functioning, the child is more of a participant-observer, aware of him or herself as separate in relation to parents as whole objects. This can form the basis for the development of subjectivity and the parental couple to be experienced at an oedipal level.” Keval, N., *Racist States of Mind: Understanding the Perversion of Curiosity and Concern*. Note that introjective pathology is characterized by the predominance of oedipal concerns and guilt.

Isn’t it really a sign of my having achieved the depressive position that I prefer my therapist to concentrate on silent processing of my clinical material rather than persistently and intrusively sharing her private thoughts with me? When I tell my therapist that I would prefer that she sit silently as an analytic listener with “actively hovering attention” am I not saying symbolically, “You and daddy are free to have all the sex you want in your bedroom, but—please—keep the door shut!” At times my therapist shows a frightening blindness to the significance of psychoanalytic distinctions. And, indeed, David E. Scharff, M.D., a Kleinian analyst, notes that an analyst’s silence can both promote as well as destroy the container. “The analyst’s silence is an essential part of his being there with the analysand, in keeping with his ideal of being a secure container ready to receive whatever she might convey verbally or non-verbally by means of projective, communicative process [citing Bion]. However, at these times the analyst’s silence destroys the container, and breaking the silence also destroys the container.” Scharff, D.E., *Psychoanalysis and Psychotherapy in China*.

I believe that Bion’s insights into group life might help us understand my relationship with my therapist particularly as it concerns my use (or non-use) of her as a container.

Bion argued that in every group, two groups are actually present: the work group, and the basic assumptions group. The work group is that aspect of group functioning which has to do with the primary task of the group – what the group has formed to accomplish; the work group will "keep the group anchored to a sophisticated and
rational level of behavior." The basic assumptions group, which operates at an unconscious level, describes the tacit underlying assumptions on which the behavior of the group is based. Bion specifically identified three basic assumptions: dependency, fight-flight, and pairing. In the paranoid basic assumption of fight-flight, the group behaves as though it has met to preserve itself at all costs, and that this can only be done by running away from someone or fighting someone or something (such as a scapegoat). In fight, the group may be characterized by aggressiveness and hostility; in flight, the group may chit-chat, tell stories, arrive late or any other activities that serve to avoid addressing the task at hand. The leader for this sort of group is one who can mobilize the group for attack, or lead it in flight. In the basic assumption fight/flight the group will recruit the most paranoid individual in the group as its leader. When acting as a Basic Assumptions group, the group acts as a closed system whereby external realities are ignored and collective dynamics rule. The basic assumptions group operates at the unconscious level and hence group members do not realize what is actually happening. Bion linked the paranoid-schizoid position to the fight/flight basic assumptions group and the depressive position to the normal operations of the rational Work Group.

In thinking about my therapist's comment that I was unable to use her as a container I was struck by the relevancy of that idea to my difficulties in groups. I have had severe interpersonal difficulties at work, possibly attributable to the fact that I do not participate in group process, that is, group members' unconscious sharing of fantasies and defenses against psychotic anxieties in basic assumptions groups. I remain an outsider. I am unable to accept the basic assumptions group's container function. Put another way, I do not use a social defense against psychotic anxieties as do persons with a higher level of groupishness. I wonder if the fact that I do not use a social defense against psychotic anxieties plays a role in the way I relate to a therapist since the role of a therapist to some extent is to serve as a container for the patient's psychotic anxieties. Possibly related to this issue is my internalization of my mother's self-soothing function. My self-soothing ability appears to be high. In what way, if any, does the individual's internalization of the mother's self-soothing function relate to his use (or non-use) of a social defense against psychotic anxieties in groups? And, correspondingly, in what way, if any, does the individual's internalization of the mother's self-soothing function affect the patient's use of the therapist as a container for primitive anxieties?

My therapist pointed out that perhaps my parents did not serve as an adequate container for me, which would account for my inability to exploit her container
function. That might be a simplistic observation. A child's creative capacities are one avenue toward transforming one's self-states—that is, states of overstimulation, depletion, or threatened dissolution. The subjective discomfort of a child's painful self-states can actually provide the child an impetus for finding the means by which such states can be altered on his own. Such transformations are a form of self-righting and self-regulation. A mother's failure to comfort a child and thereby help moderate the child's self-states can actually enhance the child's own self-regulatory capacity, enabling him to shift toward greater cohesion by himself without resort to attachment objects. Lachmann, F., "Transforming Aggression: Psychotherapy with the Difficult-to-Treat Patients." Think about it: When my mother died, at the beginning of my second semester of law school, I continued on and completed my first year at the top 15% of my class. When I was fired from my job, I didn't respond with angry protests; I simply packed up my belongings and calmly left the premises. I appear to have the creative capacity to deal with painful self-states on my own. I may have developed that adaptive ability in childhood in reaction to an unempathic mother. My therapist's simplistic conclusion that my childhood experience of failed parental containment has impaired my ability to avail myself of her containment function in therapy might well be a naive and self-serving confabulation. One of Bion's most interesting concepts described the presence of a dilemma that faces all of us in relation to any group or social system. He hypothesized that each of us has a predisposition to be either more afraid of what he called "engulfment" in a group or "extrusion" from a group. This intrinsic facet of each of us joins with the circumstances in any particular setting to move us to behave in ways that act upon this dilemma. For example, those of us who fear engulfment more intensely may vie for highly differentiated roles in the group such as leader or gatekeeper or scout or scapegoat. Those of us who fear extrusion more intensely may opt for less visible roles such as participant, voter, "ordinary citizen", etc. Bion's idea was that each of us may react upon one or the other side of this dilemma depending on the context, but that the question is always with us of how to "hold" the self, or, put another way, how to assure our personal survival within the life of the collective.

Questions arise: Is my fear of engulfment and corresponding fear of loss of identity related to my seeming inability to use my therapist as a container just as it obviates my use of the basic assumptions group as a container? Is there a relationship between these issues and high ego strength? Keep in mind that high ego strength is associated with the traits of being self-reliant, solitary, resourceful,
individualistic, and self-sufficient while the traits of being group-oriented, affiliative, a joiner and follower dependent are associated with lower levels of ego strength. Creativity is associated with a high level of ego strength. See Fodor, E., "Subclinical Manifestations of Psychosis-Proneness, Ego Strength, and Creativity." Is there a relationship between these issues and depressive anxiety? I note that Hanna Segal theorized that creativity emerges out of the depressive position. Segal, H., “A Psychoanalytic Approach to Aesthetics.”

Kernberg’s observations about the basic assumptions group as an "idealized breast mother" might offer insight into the fate of an independent-minded, creative individual in such a regressed group, an individual who has internalized his mother's self-soothing function and who is able to forego a conventionalized use of the basic assumptions group as a container. Kernberg writes: “The psychology of the group [] reflects three sets of shared illusions: (1) that the group is composed of individuals who are all equal, 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. Do Kernberg's insights about the dynamics of basic assumptions groups imply that where a therapist's unconscious self-concept is that of an idealized breast mother, specific transference-countertransference issues will arise in her therapy relationship with a creative, independent-minded patient who is able to moderate painful self-states on his own? Will that therapist experience that creative patient as a narcissistic threat to her idealized self-concept? Might we call that narcissistic threat persecutory?

The containment function is a key element in group life. Elliot Jaques writes: "Many observers have noted that there is a strikingly close correspondence between certain group phenomena and those processes in the individual that represent what Melanie Klein has called the psychotic level of human development. . . . Bion suggested that the emotional life of the group is only understandable in terms of processes at this very primitive level. . . . Groups are used by their individual members to reinforce mechanisms of defense against anxiety, and in particular against recurrence of the early paranoid and depressive anxieties. It is as though the members of groups unconsciously place
part of the contents of their deep inner lives outside themselves and pool these parts in the emotional life of the group." Jaques, E., "On the Dynamics of Social Structure: A Contribution to the Psychoanalytic Study of Social Phenomena Deriving from the Views of Melanie Klein (emphasis added)." The group-as-a-whole, in its function as a repository for the contents of group members' deep inner lives, is a container for group members' psychotic anxieties. It appears that I do not use the group as a container for my psychotic anxieties. Is my failure to do so related to my internalization of my mother's self-soothing function and my creative capacity to deal with painful self-states on my own? And what are the consequences of my failure to share with other individuals the use of the group as a container? And are my adaptive independent traits related to my depressive anxiety and my relationship with my therapist?

Jaques describes the psycho-dynamics of the complex interplay that can prevail between a paranoid majority group and a minority group struggling with depressive anxiety. Jaques' observations carry implications about the dynamics that prevail in the interaction between a paranoid fight/flight basic assumptions group and a scapegoat where that scapegoat serves as a container for the group's warded-off anxieties. Jaques writes: "Let us consider now certain aspects of the problem of the scapegoating of a minority group. As seen from the viewpoint of the community at large, the community is split into a good majority group and a bad minority—a split consistent with the splitting of internal objects into good and bad, and the creation of a good and bad internal world. The persecuting group’s belief in its own good is preserved by heaping contempt upon and attacking the scapegoated group. The internal splitting mechanisms and preservation of the internal good objects of individuals, and the attack upon and contempt for internal bad persecutory objects, are reinforced by introjective identification of individuals with other members taking part in the group-sanctioned attack upon the scapegoat. If we now turn to the minority groups, we may ask why only some minorities are selected for persecution while others are not. Here a feature often overlooked in consideration of minority problems may be of help. The members of the persecuted minority commonly entertain a precise and defined hatred and contempt for their persecutors which matches in intensity the contempt and aggression to which they themselves are subjected. That this should be so is perhaps not surprising. But in view of the selective factor in choice of persecuted minorities, must we not consider the
possibility that one of the operative factors in this selection is the consensus in the minority group, at the phantasy level, to seek contempt and suffering. That is to say, there is an unconscious co-operation (or collusion) at the phantasy level between persecutor and persecuted. For the members of the minority group [struggling with depressive anxiety], such a collusion carries its own gains—such as social justification for feelings of contempt and hatred for an external persecutor, with consequent alleviation of guilt and reinforcement of denial in the protection of internal good objects.” Jaques, E. “On the Dynamics of Social Structure — A Contribution to the Psychoanalytical Study of Social Phenomena Deriving from the Views of Melanie Klein.

In group situations, there will be an interplay between a fight/flight basic assumptions group's persecutory anxieties and my depressive anxiety. My depressive anxiety makes me a willing target of the basic assumptions group's persecutory anxiety. The group uses me as a container for warded-off anxieties. And I am unable to use the group-as-a-whole as a container. I propose that I am unable to use my therapist as a container just as I am unable to use the persecutory fight/flight basic assumptions group as a container.

But what does that say about my therapist?

Is it possible that a dominant anxiety for my therapist is persecutory anxiety (at least in the counter-transference)? Might we say that I will typically be unable to accept the container function of persecutory groups as well as individuals who are dominated by persecutory anxiety? But that leaves open the possibility that I am able to accept the container function of individuals and work groups (as opposed to basic assumptions groups) that operate at a level of depressive anxiety. Remember: Bion believed that the work group is dominated by depressive anxiety unlike the fight/flight basic assumptions group, which is dominated by persecutory anxiety.

I previously spent a year in once-a-week psychotherapy with Stanley R. Palombo, M.D., an experienced and knowledgeable psychoanalyst. I felt comfortable with him and his analytic technique, which featured analytic abstinence, reliance on free association, and minimal transference interpretation. An idealizing transference emerged. I viewed him as a rescuer (I identified him with the Wagner hero, Lohengrin, who rescues a maiden in distress, and I listened obsessively to the opera during our relationship); in my current therapy I feel I need rescue from my therapist whom I experience as overbearing and engulfing.

Do my thoughts about containment suggest that I was able to accept Dr. Palombo's container function because he was a mature individual who had achieved a stable state of mature depressive anxiety?
Thoughts about Psychoanalytic Narrative

I discussed the issue of psychoanalytic narrative with my therapist at my session on June 18, 2019. I asked her if Kleinians are concerned with analytic narrative. She didn’t respond. I said, “I don’t understand how any analytic school that doesn’t attach importance to narrative can legitimately call itself analytic.”

I shared my thought that in analysis it’s as if the patient is telling two stories simultaneously. There are the particulars of what the patient is consciously aware of talking about – but when you look at the narrative as an independent text, an entirely different story can emerge. The analyst, in my opinion, needs to be sensitive to the unconsciously-determined subtext of the manifest content of the patient’s clinical report. In my opinion the analyst cannot see deep meaning in the patient’s report unless she is sensitive to the underlying meaning of the particulars of the patient’s report as disclosed by a consideration of the context of the session as a whole.
I explained: “Have you ever heard of the Remote Associates Test? It’s a test of creativity. The test subject is given three words, and has to come up with a fourth word that relates to the three words he is given. For example, a person might be given the words ‘wrist,’ ‘dog,’ and ‘man.’ The correct response is ‘watch’ — wristwatch, watchdog, and watchman. I said that an analytic narrative is like that. The patient is consciously aware of talking about particulars like a dog, a wrist, and a man — but lurking outside the patient’s consciousness is a cohesive text or narrative that confers a special meaning to the particulars of the patient’s clinical report. The patient is talking about the concept watch but doesn’t know it. That’s basically a metaphor that gives a flavor of analytic aims which focus on the particulars of the patient’s narrative, but also on the underlying story revealed upon looking at all the connections in the narrative. I asked the therapist — “how do Kleinians assess narrative if they are constantly interrupting the patient’s narrative flow?” She had no answer.

I think of another analogy, from chemistry. Imagine that the particulars of the patient’s report are chemical elements, like sodium and chlorine. The cohesive narrative (of which the patient is not aware) is the combination of these elements—the underling narrative is about something entirely different than the particulars, it is, in fact, a story about the compound table salt.

My therapist doesn’t think in these terms at all. I could tell from working with Dr. Palombo that he was intensely focused on these very concerns, namely, the two analytic stories, as it were, being told simultaneously by the patient. The conscious story made up of particulars, and the underlying cohesive narrative of which the patient is not consciously aware.

Another example is my book Significant Moments. Throughout the book there is a manifest text, but underlying the manifest text is a subtext that floats by imperceptibly. For example, in one section I talk about the philosopher, Nietzsche writing his book, All Too Human, a story that has no sexual meaning. But the subtext is about a boy having sex with his mother.

Continuing the metaphor, when I talk about “sodium,” my therapist will begin to talk about the psychological significance of “sodium.” If I then talk about “chlorine,” she will stalk about the psychological meaning of “chlorine” for me. She has no sense that “chlorine” and “sodium,” per se are not the issue. The relevant unconscious issue for me, outside my conscious awareness and nowhere present in the manifest words of my clinical report, is the compound “table salt.” Analytic
work requires an analyst who is a patient listener, someone who is psychologically able to listen to the patient with two ears and who is not preoccupied with her self-satisfying need to give “gifts” to the patient. What the analyst gives to the patient is less important in many ways than what the analyst can elicit from the patient with her interventions.

The therapist’s technique undermines the basic tenet of narrative analysis, namely, that the object of narrative analysis is the narrative itself (the “table salt”), as opposed to the events being narrated or the experiences or character of the narrator (that is, the “chlorine” and the “sodium”). The “sodium” and “chlorine” of a patient’s clinical report are simply building blocks of a narrative, not an end in themselves.

Hollway and Jefferson write: “There is a ‘gestalt’ informing each person’s life which it is the job of the analyst to elicit intact, and not destroy through following their own concerns about the particulars of a patient’s clinical report. There are similarities between the principle of respecting the narrator’s gestalt and the psychoanalytic method of free association. By asking the patient to say whatever comes to mind, the psychoanalyst is eliciting the kind of narrative that is not structured according to conscious logic, but according to unconscious logic; that is, the associations follow pathways defined by emotional motivations, rather than rational intentions. According to psychoanalysis, unconscious dynamics are a product of attempts to avoid or master anxiety. Freud allowed the patient to ‘choose the subject of the day’s work’ in order that he could start out from whatever surface [the patient’s] unconscious happens to be presenting to his notice at the moment.’ By allowing the patient to set the agenda, ‘this was the method of truly free associations.’ Anxieties and attempts to defend against them, including the identity investments these give rise to, provide the key to a person’s gestalt. By eliciting a narrative structured according to the principles of free association, therefore, we secure access to a person’s concerns which would probably not be visible using a more traditional method. Hollway, W. and Jefferson, T., “Researching defended subjects with the free association narrative interviewing method.”

In a recent therapy session I opened with comments about the up-coming summer solstice. I was setting the agenda. The therapist immediately shifted the focus, attempting to impose a relational meaning to my concerns (my personality is not relational; it is pathologically introjective, by the way). I generally recall her saying, “Perhaps you are talking about time and your feelings about the 50-minute limit on our sessions.” Did the therapist get that idea by looking at the context of the session (the “sodium” as well as the “chlorine”) or was she simply and haphazardly
imposing her relational agenda to my ambiguous concerns that could have meant anything at all – or nothing at all, for that matter?

Hollway and Jefferson continue: The principle of gestalt is based on the idea that the whole is greater than the sum of parts. Wertheimer, the founder of gestalt psychology, objected to the way that, in his view, modern science proceeded from below to above. He believed that it was impossible to achieve an understanding of structured totals by starting with the ingredient parts which enter into them. On the contrary we shall need to understand the structure; we shall need to have insight into it. There is then some possibility that the components themselves will be understood (cited in Murphy and Kovach, 1972, p. 258-9).

This is the principle which we try to apply to our understanding of the ‘whole’ text. (For examples of the use of the gestalt principle in biographical-interpretative research, see Rosenthal, 1990 and 1993; Rosenthal and Bar-On, 1992; and Schutze, 1992.) Wertheimer’s primary law, that of ‘place in context’ (that significance was a function of the position in a wider framework), addressed exactly the problem of decontextualization of text which is inherent in the code and retrieve method. Wertheimer emphasized that ‘parts are defined by their relation to the system as a whole in which they are functioning’ (Murphy and Kovach, 1972, p. 258). Similarly the structuralist movement which started in social anthropology and linguistics emphasized that meanings could only be understood in relation to a larger whole, whether it be the culture, the sentence or the narrative.” Hollway, W. and Jefferson, T., “Researching defended subjects with the free association narrative interviewing method.”

Additional Thoughts about Narrative and Unconscious Content
Back in the 1980s the psychoanalyst Hartvig Dahl, together with the linguist Virginia Teller, Ph.D. tape-recorded and linguistically analyzed the clinical reports of a young male patient of Dahl’s. The journalist Janet Malcolm was permitted to listen to a tape-recording of one 50-minute analytic session that Dahl considered one of the most significant sessions in the multi-year analysis.

Janet Malcolm later wrote: Dahl has attacked his recorded analysis (1,204 sessions) on many fronts, and his attention has finally come to rest on a single session: the fifth hour of the analysis. Through intensive linguistic and logical analysis of the verbatim transcript of this hour, Dahl and Teller are attempting to lay bare the mental processes of
analysts as they listen with “closely hovering attention” to a patient’s utterances and find themselves forming hypotheses about their unconscious meaning. For embedded in the transcript, like a message written in invisible ink, are innumerable, unmistakable traces of the patient’s unconscious motives. Invisible to the naked eye as such, they come into glaring view under the special linguistic and logical microscopy devised by Dahl and Teller for their singular demonstration of the existence of the unconscious. What every analyst implicitly “knows” about his patient Dahl and Teller are attempting to explicitly show with their textual analyses.

Dahl proposed that I listen to Session Five as a preliminary to studying the annotated transcript. He said that any other hour of the analysis would have served his purposes as well, but that Session Five happened to be a particularly rich hour – a kind of microcosm of the whole analysis, like the overture of an opera in which all the themes are announced. At the time of its recording, however, Dahl recalls, the session hadn’t struck him as particularly significant; only in retrospect, after the analysis was over, could he make out the fifth hour’s prophetic character. He seated me in a small room borrowed from some vacationing sex researchers, threaded a tape into a large recording machine, showed me how to start and stop the tape, and left the room. I paused before turning on the machine, a little awed by what I was about to do: eavesdrop on a patient’s confessions to his analyst. I remembered Freud’s admonition in the first of his Introductory Lectures: “You cannot be present as an audience at a psycho-analytic treatment. You can only be told about it; and, in the strictest sense of the word, it is only by hearsay that you will get to know psycho-analysis .... The talk of which psycho-analytic treatment consists brooks no listener.”

I turned on the machine, and listened for fifty minutes to a young man’s halting, rambling soliloquy describing ordinary trivial events and expressing commonplace thoughts and feelings. It was like listening to a boring, self-absorbed acquaintance. Freud had been right: an outsider eavesdropping on an analytic session gets almost nothing from it; he is like an eavesdropper on a conversation (or monologue) in a foreign language. Only later, on reading the annotated transcript of the hour, did I laboriously decode the secret messages from the unconscious that the patient had wafted toward his analyst years before, and which Dahl, following Freud’s instructions about loose, desireless, undirected listening, had “intuitively” grasped.
In Session Five, Dahl spoke only twice. He sounded impressive—like an older, wiser, more benign and authoritative version of himself. When I told him of this impression, he laughed, and said, “I was pretty impressed with myself, too.” He said that he deliberately spoke very little in the first years of the analysis so that no one could say he had “suggested” anything to the patient. In the later years of the analysis, he talked more. (Another precaution Dahl took was to enlist the supervision of the eminent New York Psychoanalytic Institute analyst Jacob Arlow, with whom he met weekly throughout the analysis.)

The analysis developed along the standard Oedipal lines that classical analyses of mildly neurotic patients are expected to follow. Only a relatively small part of the total analysis has been transcribed; transcription is costly, and the funding from public and private foundations that Dahl depends on for his research is modest and unreliable. He has been working on Session Five for three years now. He thinks he is on the verge of a major breakthrough. His belief in science—his conviction that “the world is an orderly place”—keeps him at his task, in resolute pursuit of knowledge that analysts have trouble grasping and that scientists in other fields have little interest in acquiring.

I find this observation by Janet Malcolm amazing. “It was like listening to a boring, self-absorbed acquaintance.”

Therapists say to me: “You don’t talk about what matters. You don’t talk about important things.” No. That’s not the problem. Dr. Dahl said session 5 was one of the most important sessions—a session that to a non-analytic ear was meaningless solipsist drivel. It’s not that I don’t talk about important things, it’s that non-analysts or inadequately-trained analysts are unable to see the significant in the seemingly insignificant. Only a therapist who doesn’t recognize the imperative for “loose, desireless, undirected listening” will view my clinical reports as deficient.

Two times I said to my previous treating psychiatrist, Dr. Palombo, a psychoanalyst: “I don’t think I am talking about important things” Two times he replied: “You’re doing fine.”

December 19, 2019
I spent some time talking about the essay I wrote, “Reflections of a Solitary on a Snowy Afternoon in January.” I reviewed the essay from memory, talking about the diverse collection of ideas in the essay: getting lost in myself during the snow storm that I witnessed, the structure of ice crystals as a metaphor for psychic determinism in psychoanalysis, the structure of buildings that affords both aesthetic satisfaction as well as provides structural integrity to the building, Wagner’s Festival Theater at Bayreuth (a building), from Wagner’s theater I moved into the issue of narcissism: the fact that I felt I grew up in the “theater,” with my parents and I only actors, not real people.

My therapist became uneasy with my associative presentation. She told me that I was engaged in a “frenzy of ideas” that were hard to follow. This reminds me of an earlier session in which she cut me off during my train of associations with the angry comment: “You got lost in the woods.”

I know this sounds grandiose, but I wonder if she can work with a gifted patient?

Let’s review the pertinent characteristics of creative and gifted persons:

The noted psychiatrist Silvano Arietti, M.D. wrote about creative persons: “They are more capable of holding many ideas at once and comparing more ideas, hence making a richer synthesis.”

Francis Heylighen is a Belgian cyberneticist investigating the emergence and evolution of intelligent organization. He presently works as a research professor at the Free University of Brussels, where he directs the transdisciplinary research group on “Evolution, Complexity and Cognition” and the Global Brain Institute. Heylighen has written about the following traits in gifted persons:

– they create seemingly unrelated ideas

– they have original and unusual ideas

– they have a need to search for the inherent pattern, logic or meaning in a set of data information, while average people prefer to have the pattern, logic, or meaning already generated and explained.
[The search for pattern and meaning in a set of data describes the work of the psychoanalyst who looks for patterns and meaning in the patient’s narrative. ]

Another text emphasized the following:

–they show advanced comprehension of metaphors (such as comparing an ice crystal with analytic psychic determinism).

In one text, Heylighen talks about a concept known as “propagation depth” that might have relevance to “free association” in psychoanalysis. Heylighen writes: “In the meantime, the concept of propagation depth will need to be further developed and tested to ascertain its value as an explanatory model for the brain mechanisms underlying intelligence and creativity. Empirical tests of the model are not obvious, given that our methods of observing brain processes are still not sufficiently refined to follow individual thoughts as they propagate between neuronal assemblies. It may be possible to design more indirect tests by extending traditional methods such as measurement of divergent thinking skills, free association, or priming. For example, a testable prediction deriving from the model would be that more intelligent people, having higher propagation depths, can be primed more easily via indirect associations, like in the example where the word “lion” via its association to “tiger” primes the mind to more quickly recognize the word “striped.” Heylighen, F., “Characteristics and Problems of the Gifted: neural propagation depth and flow motivation as a model of intelligence and creativity.” Does my therapist have high propagation depth? What would it mean for her analytic work if she does not have this trait? Is there a relationship between “propagation depth” and analytic free association? I don’t know.

C. Robert Cloninger, M.D. is an American psychiatrist and geneticist noted for his research on the biological, psychological, social, and spiritual foundation of both mental health and mental illness. Perhaps, I am misapplying Cloninger’s ideas, but I wonder if the following passage in one of Cloninger’s papers hints at why some psychoanalysts are attracted to classical analytic theory, while other analysts are only concerned with relational or interpersonal issues. Might it have to do with “flow states” and “flow motivation?”

“Likewise, in clinical therapeutic work, I began to face the reality that people simply do not think or change in a predictable linear sequence of developmental steps.
When a person’s thoughts are observed in their natural state of flow (i.e., in free association as described by Freud), they often range widely over many concerns, such as sexuality, aggression, attachments, intellectual questions, and spirituality—all in a rapid succession of complex patterns during one meeting. Likewise, our interpersonal relationships, which substantially influence psychological development, are not predictable from information about the individuals in isolation from one another. Rather, our relationships generally depend on factors that are unique to the particular relationship and its context. Furthermore, our interpersonal relationships with individuals vary across many aspects of life, including sexuality, aggression, emotional attachments. Cloninger, C.R. Feeling Good: The Science of Well-Being.

In psychology a flow state, also known colloquially as being in the zone, is the mental state of operation in which a person performing an activity is fully immersed in a feeling of energized focus, full involvement, and enjoyment in the process of the activity. In essence, flow is characterized by the complete absorption in what one does, and a resulting loss in one’s sense of space and time. Gifted persons are believed to have high flow motivation. When gifted persons are engaged in a task, others might have the sense, as David Callet would say, that they are working hard.

Might I conjecture that persons in analytic treatment can achieve a flow state during free association? Would this be especially true of gifted analytic patients? Might this “analytic flow state” or “high flow motivation” be off putting for a analyst whose work focuses on interpersonal relationships where flow does not come into play? Interesting idea.

With my therapist there is, as far as I can see, no “subversion of the ego defenses.” My therapist emphasizes the need to bring associations under the conscious control of the “observing ego.” Using the therapist’s recommendation, unconscious material or ego dystonic material might be inhibited.

My therapist’s ideas about free association seem problematic and perhaps uninformed. There is common agreement that free association involves the following characteristics:
— The purpose of therapeutic free association is to access “primary process” thinking, which is necessarily disjointed (and not a straightforward, linear narrative).

— [It] . . . involves allowing what comes to mind to be spoken, selecting nothing and omitting nothing, and giving up any critical attitude or direct forcing in the face of a problem. [Heaton, 2000]

— [It] draws on those freely wandering and undirected associative thoughts that constitute primary process thinking. [Andreasen et al., 1995]

Free association. The patient’s attempt to follow the so-called “fundamental rule” of spontaneously verbalizing whatever comes to mind in the psychoanalytic situation without selective editing or suppression of what is presumed to be irrelevant or important or is felt to be distressing. Freud believed that due to psychic determinism, free association would reveal unconscious repressed material. Edinburgh International Encyclopedia of Psychoanalysis.

**November 27, 2019**

My psychotherapist seems to think she’s proficient in her ability to understand and apply Bion. I have my doubts. What comes to mind is a college physics student who thinks she has mastered string theory. Bion is not easy to understand — to say the least; the thought of an analytic trainee usefully applying Bion with a patient is something I cannot grasp.

I have a specific concern about my therapist’s understanding of Bion. Bion created the concepts of beta elements and alpha function. As I understand it (and I probably misunderstand it) beta elements are primitive “feelings” that cannot be put into thoughts. Through mother’s containment of the infant, the infant develops the ability to transform these beta elements into alpha function that can go into thoughts.

My concern is whether my therapist fully grasps the fact that simply because a patient cannot verbalize his feelings does not mean that those feelings are beta elements. There can be several reasons why a person cannot verbalize his feelings. It can be beta elements. But it can also be repression. Repressed material — un-verbalizable, unconscious feeling — is never beta elements. It is always alpha function. Bion specifically said that only alpha function can be repressed. The ego cannot repress
beta elements. Another issue is preverbal experience. An adult cannot talk about—
that is, put into words — his feelings from infancy because the feelings did not
emerge at a time when the infant had verbal thoughts. The infant does not think in
words. But that preverbal material is not necessarily beta elements. I would guess that
in mentally healthy adults, a lot of preverbal experience tends to be alpha function
and not beta elements. Though an infant cannot put feelings into words, the infant
— with adequate containment — is capable of transforming beta elements into alpha
function.

These concerns are raised by the coercive way my therapist tries to get me to put
things into conscious thoughts, as if she were dealing with a person with impaired
alpha function. Does she understand that there can be other reasons why a person
might be unable to verbalize mental material? In simple terms does my therapist
understand that “unconscious” and “beta elements” are two different things or does
she, to some extent believe, that “unconscious” and “beta elements” are
synonymous. Put another way, does she confuse the concept “mentalize” with
“verbalize?”

I wonder about the origin of my therapist telling me I am attacking links and
destroying knowledge. Are these statements based on her limited understanding of
Bion’s writings about thinking?

As I see it there are problems with an analytic trainee going on to Bion before that
trainee has a firm grounding in classical analysis. I barely understand classical
analysis. And I certainly do not understand Bion.

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**THERAPY SESSION: November 21, 2019**

PATIENT: I’m feeling good about seeing you once a week. It’s become tolerable for
me. I just felt overwhelmed before with seeing you twice a week. It was oppressive. I
was developing a lot of hostile feelings toward you. I used to dread coming in here
each session. Now, I actually look forward to seeing you. There’s a kind of
excitement about seeing you now. I think this once a week schedule is good for me.
I mentioned before about how I feel more comfortable feeling hungry than I am
with the feeling of satiation. I feel good about being left unsatisfied by once per
week sessions. I feel uncomfortable with the sensation of too-muchness that comes
seeing you twice a week. I like the feeling of hunger, of wanting more.
Last time I remember you said that we could use our relationship to understand my other relationships. You seemed to say that my relationship with you is representative in some way. Theoretically, yes, that must be so. My relationship with you must be related to my other relationships, but it’s hard to see how that might be so. I mean, for example, how does my obsession with Dr. P. relate to you? That’s a mystery. And my problems at work. How do my disturbed relationships in the workplace relate to you? I know that theoretically, at some level, they must be related. But it’s hard to see how that might be so, at least at a superficial level. So I was thinking about this problem. Trying to think about how my relationships in general are related to you. I mean, in a Kleinian sense, all these relationships in the outside world must be related to things at an internal object level. And I was intrigued to come across a paper about a man who became obsessed with another man. Like me and Dr. P. And the author goes into a Kleinian interpretation of that. What was going on in that man’s internal objects. His inner world. The paper is an analysis of a book titled Enduring Love. The book came out in the 1990s, I think. Then they made the book into movie in about 2004. So I brought the paper. It’s called, “A Perpetual Search for the Idealized Lost Loved Object: An Object-relations Reading of Ian McEwan’s Enduring Love.”

I want to read you a paragraph. Just one paragraph that stood out for me. This is what it says: “Unsatisfactory primary experiences in his childhood with his “unsupportive mother” as his primary love object has probably been, in Klein’s idea, the root cause of Jed’s failure in his adult object relationships and this situation has probably made him an emotionally hungry individual who has been engaged in a memorial search for his internal idealized love object. Experiencing a not good-enough facilitating environment, has impacted Jed’s later interactions, and therefore, he has not been enabled to incorporate a good-enough maternal figure deep in his psyche. Hence, he searches for an equivalent love object to satisfy him emotionally and gives him the love and support he once has missed all through his early life. This situation in Jed’s life indicates a critical failure of his development from infantile dependency to adult independence.” So maybe my obsession with Dr. P. is related to disturbances in my relationship with my mother. Well, that would be registered in my internal objects. And these internal objects also come into play in some way in the way I relate to you. But, as I say, it’s hard to see how. We need to get at that. We need to look at these things here, my internal objects.

Then with regard to my problems in the workplace, I was thinking about how depressive anxiety in me could play a role. What I see is that in groups, where a group identity has emerged, the group has regressed to a state of paranoid-schizoid
anxiety where they see the group as a whole as idealized, or all good, and they see outsiders or scapegoats as enemies who are all bad. So I seem to have problems in groups like that and I wonder if my depressive anxiety plays a role in why I have difficulties in those groups. It’s as if my inability to regress to paranoid-schizoid anxiety is a factor in my inability to fit into a regressed group that has regressed to paranoid schizoid anxiety. It could be my depressive anxiety.

THERAPIST: I don’t understand how depressive anxiety would play a role.

PATIENT: Well, anyway, you know I’m still dieting. And I just hit my target weight. When I started my diet back in August I wanted to get down to 175 pounds. Well, I just hit 175 pounds. But, you know what, I decided to keep dieting.

THERAPIST: You need to be careful. You could become anorexic.

PATIENT: I was thinking of getting down to 170 or 165. I was 165 in college. Maybe I’ll go down to 165. It’s like dieting itself has become my goal. I seem to like restricting my diet just for the sake of restricting my diet.

THERAPIST: You want control.

PATIENT: Yes, I want control. Control, planning, regimentation. Everything is planned with me. Very little is spontaneous. I don’t just let things happen. I need to plan everything. Like for example, I had the idea a few months ago that I would like a treat for Thanksgiving. And that was months ago. I decided I would get a package of cheese, anticipating that I would make a cheese omelette on Thanksgiving. So I’ve had that planned for months now. That cheese has been sitting in my refrigerator since September. So, I’m going to have a cheese omelette for Thanksgiving. That will be my special treat.

THERAPIST: So you’re going to allow yourself some cheese.

PATIENT: Yes. You know, an image just flashed in my mind when you said that. The entire time that I was talking about the cheese I didn’t think this thought. This thought didn’t register with me. But the moment you said, “You’re going to allow yourself some cheese” it reminded me of something from law school. I lived in an apartment in Spokane, Washington and I had some mice in my apartment. So I bought some mouse traps and I put some cheese on the mouse traps and I caught the mice. There were two of them. I knew the mice used to like to hang out at night in my stove. It was warm in there because of the pilot light. And I knew they were in the stove at night because I could hear the noises in the metal oven at night.
So I put the traps in the oven knowing that would be the best place to catch them. And so one night I could hear a loud banging noise. It was the mouse in the oven. I could tell what happened by the noise. He was trapped and in the few seconds before he died, he was thrashing about in the oven, banging the trap against the metal oven, which made a loud noise. And sure enough, I checked the oven right after that and he was dead in the trap. But the thing is — that thought only came to me when you said, “You’re going to allow yourself some cheese.” The thought of the trapped mouse came into my head. I guess I saw myself as the mouse.

THERAPIST: You have the feeling that I want to execute you.

[The therapist assumes that in identifying with the mouse I was expressing a fear of annihilation, that is, persecutory anxiety. But were there depressive anxieties associated with my killing the mice. It was the only time in my life that I had killed a mammal. It's interesting to note that persons who work in labs talk about the remorse associated with sacrificing mice in medical experiments. "I used to work with mice, and eventually the squeamishness went away. But I never really got over feeling guilty (or not guilt, per-se, but.... sorry!). It was hard for me. A senior lab member told me something that I found really helpful: She felt the same way, and she tried to 'give back' to the animals in other ways in her life. She became a vegetarian. She also donated time to animal shelters (she was already a veterinarian, so she probably would have done this anyways). She thought it helped to keep the karmic balance." The senior lab member forwent meat as recompense to deal with the depressive anxiety associated with killing lab mice. Is there a tie-in to anorexia: foregoing food because of guilt feelings? Cf., Friedman, M. "Survivor Guilt and the Pathogenesis of Anorexia Nervosa.”]

PATIENT: Maybe. Anyway, Dr. Shengold in his book Soul Murder about child abuse — he talks about rats and how child abuse victims will associate to rats—and mice, I guess. So maybe this has something to do with child abuse. I don't know.

And you know we were talking about the issue of hunger and satiation. And I was thinking about how my satiation in emotional areas actually affects my physical hunger. I love the Wagner opera Gotterdammerung. And back 10 years ago I got to see it for the first time. I remember the exact date. It was Sunday November 15, 2009. It was a matinee performance at the Kennedy Center. So the opera started early and it was about 5 hours, so I got back home in the early evening. But you know I was so emotionally overwhelmed by the music, I couldn’t eat. I remember I ate nothing that night because I just wasn’t hungry. And I thought that was
interesting. It kind of shows how my emotional elation will affect my hunger, as if feelings and food were transferable for me. Music satisfies my emotional hunger and can even satisfy my physical hunger.

Another thought came into my mind. It’s related in my mind. This goes back to when I was 13 years old. I remember it was in the spring of 1967. I was in the 8th grade. It was the second Saturday in April 1967. So my aunt and uncle — my mother’s older sister — had a house in the suburbs and they had this expensive stereo system. And the classical music station in Philadelphia was broadcasting Gotterdammerung and my aunt said I could come up to her house to listen to Gotterdammerung on her stereo. So my mother and I went up to my aunt’s house in the early afternoon and I got to listen to the whole opera on the expensive stereo. They went out. My aunt, uncle and my mother. They didn’t want to listen to the opera all afternoon. So I was home alone all afternoon listening to the opera and I got hungry. So I went to the kitchen and ate a can of baked beans. And I was thirsty so I drank cranberry juice. It was an unopened container of cranberry juice. I ended up drinking the whole container of cranberry juice during the afternoon. So in the early evening they came back home. The opera was over. My aunt went into the kitchen to make dinner. And she saw the baked beans can and the cranberry juice bottle in the trash can. And she came into the living room and she started yelling at me, “You couldn’t wait! You couldn’t wait! What did you think, that I wasn’t going to feed you?” And her demeanor and her rage were such that I thought she had to be joking. I thought it was all a joke. I couldn’t believe that she could get so angry about a can of baked beans. Then I could see it was no joke. She was enraged. She had explosive anger. She was literally enraged. And she went back to the kitchen. My mother was there and I heard my mother say submissively to my aunt, “I’ll pay you back for the can of baked beans and the cranberry juice.” And I noticed that my aunt didn’t say, “You don’t have to do that.” It was like I committed grand theft, like it was a crime. I couldn’t believe it. I thought it was unbelievable. I found it very disturbing. So I have my own analytical thoughts about what was going on in my aunt’s mind. Maybe this is a projection on my part, but what I think is that while they were out, my aunt had an unconscious fantasy of me being hungry back home. She unconsciously imagined me starving. And that gratified her because then she could imagine that she — she and no one else — would rescue me from my starvation. She would be my rescuer. And my act of eating the baked beans interfered with that fantasy. I had rescued myself and didn’t wait for her to rescue me. Well, that’s my speculative idea about what was going on in her head. And then there’s another thing. My aunt had had kidney disease.
THERAPIST: Your aunt probably had UTI [urinary tract infection].

[This is an instance of my therapist confabulating based on inadequate evidence. In fact, years earlier, my aunt had surgery to remove one of her kidneys. My sense is that my aunt was simply concerned about keeping her remaining kidney healthy, not about UTI. I never heard my aunt or mother talk about UTI.]

My aunt drank cranberry juice for health reasons. At least she thought it was healthy to drink cranberry juice. So it was kind of like medication for her. And I denied her that. I drank her cranberry juice. And I imagine that at some level she viewed my drinking her cranberry juice as a physical assault on her. As if I was trying to kill her. So like my coworkers thought I was going to kill them. My supervisor said she was afraid I was going to kill her. I don’t know, maybe things are all related.

THERAPIST: Your supervisor said she thought you were going to kill her?

[I told my therapist that anecdote several times before. Typically, she doesn’t remember what I tell her — even striking things.]

You must have found that insulting.

PATIENT: Yeah, I found that insulting. Like some of my previous therapists would say, “Your feelings were hurt.” But that wasn’t it. It was insulting. You’re right. I found that insulting.

ADDITIONAL THOUGHTS:

In early childhood I struggled with food. I ate little and was seriously underweight. My parents continually fretted about my food refusal. My pediatrician told my parents when I was about three years old, “I’ve seen chickens fatter than him.” The doctor prescribed a tonic to stimulate my appetite; I recall that it was green in color and mint-flavored. My mother gave me a tablespoon of the tonic about an hour before dinner. I remember hating the tonic. I resisted being coerced into eating. My mother eventually realized that the tonic was ineffective, which gave me immense satisfaction. In my mind, I could now resume my food refusal. I had control.

A research study on anorexia nervosa states, applying a Kleinian analysis: “It appears that the anorexic is unconsciously motivated, at least partly, by her desire to repudiate any experience of dependency, separateness, loss, frustration, envy, fear, guilt and helplessness.” Gilhar, L., “A Comparative Exploration of the Internal Object Relations World of Anorexic and Bulemic Patients.” These observations seem
significantly related to my own fears of maternal engulfment as well as my dismissive avoidant attachment style. It has been found that anorexics have anxieties of being devoured; they fear loss of love, engulfment or of being consumed by the “evil” part. Further, anorexics have a need for separation, independence, control and protection from their “evil”, self-destructive parts and a need for containment. They also have a need for their own sense of control and escape from the controlling mother-figure. See Gilhar.

For the anorexic food is the symbolic equivalent of mother. The anorexic sees mother not as the provider of food but, symbolically, food itself. The anorexic attempts to separate from her mother and untangle her body from her mother’s by not taking her in. Thus, what she plays out by not eating is an attempt to create the concept of a boundary between her body and her mother’s. The reason why she can never express her separateness is because she fears the annihilation. The anorexic has intense fear of loss, thus, she is unable to ask for what she needs and accepts love in any form that it comes – food. The anorexic has an ambivalent relationship with food because there were such conflictual messages projected into it. See Gilhar.

Research confirms an association between dismissive avoidant attachment and anorexia. “[Dismissing avoidant] patients tend to maintain an avoidant, detached, or distanced position in relation to attachment. Such attitude implies the use of deactivation strategies in order to keep distressing emotions under control after attachment activation. This dismissing attitude represents a defensive turning away from potentially painful emotional material, similar to the anorexic’s denial of hunger. . . . The predominance of dismissing and unresolved adult attachment and analogous personality style groups (avoidant, fearful) in eating disorder samples is striking, especially for anorexia.” Delvecchio, E., “Anorexia and Attachment: Dysregulated Defense and Pathological Mourning.” I note that Westen identified a high-functioning, perfectionistic subpopulation of anorexics who resemble introjective depressives. These individuals tend to be conscientious and responsible; self-critical; set unrealistically high standards for themselves and are intolerant of own human defects; are competitive with others (whether consciously or unconsciously); expect themselves to be perfect; take pleasure in accomplishing things; and tend to feel guilty. Westen, D. and Harnden-Fischer, J., “Personality Profiles in Eating Disorders: Rethinking the Distinction Between Axis I and Axis II.” Like persons in this anorexia subpopulation, 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 their own exacting standards. Blatt, S. J., & Shichman, S., “Two Primary Configurations of Psychopathology.”

Like the individual with a dismissive avoidant attachment style the anorexic is able to survive her worst unacknowledged fear, namely, the loss of love and the object. In her anorexic world she feels powerful and self-sufficient, she feels omnipotent and in control of what goes in and out of her body. She attempts to negate her dependence on the object. Furthermore, she feels omnipotent in the face of death. See Gilhar. People with a dismissive style of avoidant attachment tend to agree with these statements: “I am comfortable without close emotional relationships”, “It is important to me to feel independent and self-sufficient”, and “I prefer not to depend on others or have others depend on me.” People with this attachment style desire a high level of independence. The desire for independence often appears as an attempt to avoid attachment altogether. They view themselves as self-sufficient and invulnerable to feelings associated with being closely attached to others. They often deny needing close relationships. Some may even view close relationships as relatively unimportant. Not surprisingly, they seek less intimacy with attachments, whom they often view less positively than they view themselves. Investigators commonly note the defensive character of this attachment style. People with a dismissive-avoidant attachment style tend to suppress and hide their feelings, and they tend to deal with rejection by distancing themselves from the sources of rejection (e.g. their attachments or relationships).

The anorexic’s struggle with autonomy and control over the self parallels the drive for self-sufficiency found in persons with dismissive-avoidant attachment. “As the anorexic deprives herself of food and objects, she feels omnipotent, in control and unthreatened by death. She triumphantly projects into her external world of objects that they have nothing she desires nor needs in order to exist, and that internally she has all she needs to survive. Hence, she maintains the delusion that she does not need, that she is self-sufficient and that she is independent of her object. ‘In phantasy, ‘no needs’ means no separation, for being entirely self-sufficient prevents any awareness of dependency needs in relation to the self. If desire does not exist, mother unconsciously need not exist. The connection of both birth and early nurturing and dependence can be denied. By starving it need never be known.’ Furthermore, it seems that she desperately attempts to barricade any object from
entering her ‘ideal’ internal world. With this said, it appears that, unconsciously, she is punishing the external objects for being unable to meet her needs as they watch her fade away.” See Gilhar.

I wonder if the following observations found in another paper on anorexia offer hints about my obsession with my former primary care doctor, Dr. P. as an idealized “mirror image” object. Gaynor writes: “The anorexic refuses the symbolic dependency which ties her to the signifiers of the Other. She wishes to have her own independence and become separate from every object. She is unwilling to be regulated by the jouissance of the drive. The subject no longer wishes to be swallowed up by the desire of the Other. Through anorexia she can introduce a separating element between herself and the abusive jouissance of the Other. ‘The only Other that matters to her is the Other of the reflected mirror image, the Imaginary Other, the idealized similar one, the Other as an ideal projection of her own body 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 thin body.’ The anorexic protests against being subjected to the signifiers of the Other. She does not wish to be subject to the desire of the Other. Dependency [as in dismissive avoidant attachment] is to be avoided at all costs as the anorexic strives for mastery and to be separated from the demand of the mother (emphasis added).” “If I have an idealized similar one (twin), I will not need the object, food.”

Are these observations related to Stanley Coen’s ideas about twin transference? Coen writes that twin transference, together with all twin fantasies, subserves multiple functions, particularly gratification and defense against the dangers of intense object need. In this formulation, the twinlike representation of the object provides the illusion of influence or control over the object by the pretense of being able to impersonate or transform oneself into the object and the object into the self. Intense object need persists together with a partial narcissistic defense against full acknowledgment of the object by representing the sought-after object as combining aspects of self and other. Coen, S.J. and Bradlow, P., “Twin Transference as a Compromise Formation.” “If I had a twin, it would extinguish my need for a true other.”

Then too, are these observations related to Kohut’s case of Mr. U who defended against fear of engulfment by mother (who has a breast) by his idealization of a
distant but desired and disappointing father? Kohut’s patient Mr. U who, turning away from the unreliable empathy of his mother, tried to gain confirmation of his self through an idealizing relationship with his father. The self-absorbed father, however, unable to respond appropriately, rebuffed his son’s attempt to be close to him, depriving him of the needed merger with the idealized self-object and, hence, of the opportunity for gradually recognizing the self-object’s shortcomings. Cowan, “Self and Sexuality.” “If I had father, I wouldn’t need mother (who has a breast).” Notably, Mr. U’s dilemma parallels the recognized dynamics found to prevail in the anorexic’s relationship with both parents: “Several clinical investigators consider that the father is experienced by his anorexic daughter as minimally involved, inadequately responsive to her, and unable to foster her autonomy by providing ‘a benevolent disruption of the mother–child symbiosis.’ He is unable to facilitate the daughter’s sense of being special and lovable.” Bers, S.A., et al., “An Empirical Exploration of the Dynamics of Anorexia Nervosa: Representations of Self, Mother, and Father.”

Might my defenses against object need help explain the problem of scapegoating I experience in groups? Kernberg writes: “The psychology of the group, then, reflects three sets of shared illusions: (1) that the group is composed of individuals who are all equal, 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 (emphasis added).”

In group situations I seem to want symbolically to avoid being fed by the “idealized breast mother” at any cost. I do not participate in group process; that is to say, I do not share unconscious feelings and fantasies with the group. I will thereby be an outsider in groups, and, as an outsider, I set myself up for attack by group members, who view me as an alien threat to group cohesion. “If I remain independent, I won’t need the group (breast mother).”

And because of depressive anxiety I get a psychological gratification from being attacked by the hated group. Elliott Jaques describes the psychodynamics of the complex interplay that can prevail between a persecuting (paranoid) majority group and a minority group struggling with depressive anxiety.
Jaques writes: “Let us consider now certain aspects of the problem of the scapegoating of a minority group. As seen from the viewpoint of the community at large, the community is split into a good majority group and a bad minority—a split consistent with the splitting of internal objects into good and bad, and the creation of a good and bad internal world. The persecuting group’s belief in its own good is preserved by heaping contempt upon and attacking the scapegoated group. The internal splitting mechanisms and preservation of the internal good objects of individuals, and the attack upon and contempt for internal bad persecutory objects, are reinforced by introjective identification of individuals with other members taking part in the group-sanctioned attack upon the scapegoat. If we now turn to the minority groups, we may ask why only some minorities are selected for persecution while others are not. Here a feature often overlooked in consideration of minority problems may be of help. The members of the persecuted minority commonly entertain a precise and defined hatred and contempt for their persecutors which matches in intensity the contempt and aggression to which they themselves are subjected. That this should be so is perhaps not surprising. But in view of the selective factor in choice of persecuted minorities, must we not consider the possibility that one of the operative factors in this selection is the consensus in the minority group, at the phantasy level, to seek contempt and suffering. That is to say, there is an unconscious co-operation (or collusion) at the phantasy level between persecutor and persecuted. For the members of the minority group [struggling with depressive anxiety], such a collusion carries its own gains—such as social justification for feelings of contempt and hatred for an external persecutor, with consequent alleviation of guilt and reinforcement of denial in the protection of internal good objects (emphasis added).” Jaques, E. “On the Dynamics of Social Structure — A Contribution to the Psychoanalytical Study of Social Phenomena Deriving from the Views of Melanie Klein.

**November 23, 2019**

Sometimes my therapist will castigate me with the phrase: “You are not taking in.” In other words, she is offering me valuable interpretations, but I resist internalizing them. I have the impression she thinks that’s a “bad” thing in a technical sense, that is, it is my persecutory fears that cause me to resist “taking things in.”

Melanie Klein specifically addressed this issue. “Not taking in” can also be a resistance to the therapist based on “depressive anxiety,” not necessarily persecutory anxiety.
Klein (1935) postulated in “A contribution to the theory of manic-depressive states”:

● “the anxiety of absorbing dangerous substances destructive to one’s inside will be paranoiac, while the anxiety of destroying the external good objects by biting and chewing, or of **endangering the internal good object by introducing bad substances from outside into it will be depressive.** Again, the anxiety of leading an external good object into danger within oneself by incorporating it is a depressive one.”

Do I have a fear that my absorbing my therapist’s contribution might endanger (contaminate) my internalized good object? That’s depressive anxiety not persecutory anxiety.

These ideas have important implications about a Kleinian interpretation of anorexia nervosa, a disorder that can be seen to involve either persecutory or depressive anxieties or a combination of both. In anorexia nervosa, the individual refuses to “take in” food.

Reminds me of Nietzsche’s aphorism: “There are no moral phenomena. There are only moral interpretations of phenomena.” In Kleinian analysis I have come to see that something is often not necessarily persecutory anxiety or depressive anxiety — it could be either. An analyst labeling something either persecutory or depressive can reflect the analyst’s own countertransference. If the patient does something that pleases the analyst, then she might be disposed to call that “depressive.” Whereas, if the analyst doesn’t like something about a patient, she might be disposed to call it “persecutory.” But if something can be either depressive or persecutory, then the analyst’s labeling can be countertransference.

**November 18, 2019**

My problem in groups is my fear of engulfment by the group. I don’t homogenize. While everybody is running around losing their heads, I don’t lose my head. I wonder if my therapist understands this?

I am reminded of the Rudyard Kipling poem, "If."

If you can keep your head when all about you
  Are losing theirs and blaming it on you,
If you can trust yourself when all men doubt you,
  But make allowance for their doubting too;
If you can wait and not be tired by waiting,
Or being lied about, don’t deal in lies,
Or being hated, don’t give way to hating,
And yet don’t look too good, nor talk too wise . . .

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

In cohesive groups a paranoid dynamic can arise. In the paranoid regressed state group members view the group as a whole as idealized, or all good, and view outsiders or scapegoats within as enemies who are all bad. "The homogenized group is the most primitive and regressive; it conducts a collective flight from separation anxiety. This group is characterized by a lack of self-other discrepancy and is a psychosocial forerunner to the separation-individuation phase of infantile attachment. Individuation is minimal to absent. As the infant is attached to and totally dependent on the caregiving parent, homogenized-group members are fearful of and simultaneously merged to their leader. As group members they act as one, indistinguishable and undifferentiated. Thus, for the most part, they do not discriminate between self and others. More worrisome, they isolate themselves from outsiders, becoming detached and withdrawn from the external object world. The dangers of losing touch with reality, group isolation, and cultlike behavior are organized around the personality of the leader." Diamond, M.A., Discovering Organizational Identity: Dynamics of Relational Attachment.

It is precisely these dynamics that I do not participate in when I associate with groups. I do not regress to a state of paranoid-schizoid anxiety and share that anxiety state with other group members. Because of my failure to regress, or homogenize, I remain an outsider and subject to attack by group members, who view me as a threat
to group cohesion. My relationship to groups is in some way comparable to that of the so-called lone holdout on a jury. Research shows that an individual's creativity may play a role in whether he might become a lone holdout on a jury. "Those who make their livings by 'thinking outside the box' or by virtue of their personal creativity (e.g., artists, musicians, researchers) seem more likely than others to be self-referential and less likely to bow to the pressure of the majority. These are individuals who respect their own views to an unusual extent because their livelihoods depend on their creativity in a more singular way." Julie Blackman, J. and Dillon, M.K., "The Lone Holdout Juror."

Paranoid group dynamics, as I describe them, might seem fanciful; actually they occur at the highest levels of functioning. Irving Janis looked at the ways in which people make decisions under external threats. This interest led Janis to study a number of "disasters" in American foreign policy, such as failure to anticipate the Japanese attack on Pearl Harbor (1941); the Bay of Pigs Invasion fiasco (1961); and the prosecution of the Vietnam War (1964–67) by President Lyndon Johnson. He concluded that in each of these cases, the decisions occurred largely because of groupthink, which prevented contradictory views from being expressed and subsequently evaluated. According to Janis, groupthink occurs when people are overly willing to compromise in order to reach consensus within a group. That is, those who are opposed to the general consensus are more likely to acquiesce with the other group members in order to appease the group and so reach a unanimous decision. As Janis noted, people are susceptible to groupthink when they are truly engaged in an in-group, and the motivation for unanimity precludes them from realistically assessing and considering other opinions. Imagine a lone dissenter in the Johnson White House telling LBJ: "This Vietnam is a rabbit hole you don't want to get involved in." What would LBJ say? "Everybody in the White House is telling me a different story. In fact, they are unanimous in their view we need to prosecute this war."

November 16, 2019

In my book, Psychotherapy Reflections, I talk about the “Absent Good Mother” in connection with my thoughts about my last therapist.

- As I have written elsewhere, I strongly suspect that for this therapist the absent Good Mother is indistinguishable from the present Bad Mother (the frustrating, aggressive, or seductive mother). This became plainly apparent earlier in this session. When I told the therapist that my attachment insecurity – in the form of my adult dismissive avoidant attachment style –
would have been the result of my relationship with a rejecting mother (the “Bad Mother”), she was unable to process that and had, at three previous sessions, failed to see that my perception of myself as an intruder in my family was intimately bound up with my lived experience with an inadequate or rejecting mother. In effect, the therapist equates maternal absence with maternal empathic failure so that in the end there can only be one outcome: an infant whose proximity seeking with mother is thwarted, an infant who is denied mother’s love. But that’s clearly not true. An infant’s struggles with a lack of maternal empathy are based on faulty interactions with mother that result in pathological adaptations or psychic structures specific to those faulty interactions – and not maternal absence. An infant that develops faulty psychic structures is not necessarily struggling only with a lack of maternal love.

At another point in the text, I state:

- The only emotional pain of the patient is loneliness (that is, the absent good mother or “the loss of maternal protection”). The therapist is unable to process a patient’s feelings in relation to his “internal objects” (introjective pathology). I suspect that the therapist has difficulty processing the idea of the “present bad mother” (as well as “bad internal objects”) which seems related to her inability to work with a patient’s negative transference.

Today I was reading a paper titled: “The Depressive Position” by Jane Temperley. In that paper the author talks about Bion’s specific thoughts about this issue.

As the child withdraws his projections, he becomes increasingly aware of his own mixed nature and of the tension that exists within him between his loving and destructive impulses. Since it is no longer a bad ‘other’ who is felt to be responsible for the aggression he has projected into the world around, the child begins to recognize his own responsibility and to experience guilt. This capacity to recognize and bear guilt is one of the reasons for Klein’s choosing the term ‘depressive’ for this position.

The reduced use of projection and the greater integration of both the ego and the object leads to a more pronounced sense of separateness and of the infant’s dependence on a separate other person. In the paranoid-schizoid position, Bion has remarked that there is no sense of an absent good object – the infant is either in the presence of a good object or, if the mother is unavailable, it is in the presence of a bad object. With the depressive position the child becomes aware that it does not control or possess the good object but needs it and can miss and pine for it in its absence. The child feels loss and mourning for a good object, rather than denial or betrayal by what is felt to be a bad object. Because of this new sense of its dependence on the object and of the dangers to the object from the child’s own destructiveness, this stage is characterized by concern for the object. It is also marked by the development of the desire to repair and restore the object which the child fears it has
damaged by its attacks. The capacity for reparation is one of the most powerful manifestations of the life instinct.

I knew I had read this somewhere and it was driving me nuts not being able to think of where I had read it.

I think about Dr. P and me. For me he is absent but idealized. Perhaps the following text helps explain my obsession with Dr. P. The text is my paraphrase from the following paper:

The paper is a psychoanalytic study of the novel, *Enduring Love*, about a man who becomes obsessed by another man. Sound familiar?

*Unsatisfactory primary experiences in childhood with an “unsupportive mother” as a primary love object can, in Melanie Klein’s idea, be the root cause of an individual’s failure in his adult object relationships and this situation can create an emotionally hungry individual who has been engaged in a memorial search for his internal idealized love object. Experiencing a not good-enough facilitating environment, that is, having not been able to incorporate a good-enough maternal figure deep in his psyche, impacts an individual’s later interactions. Hence, he may search for an equivalent love object to satisfy him emotionally and give him the love and support he once missed all through his early life. This situation in an individual’s life indicates a critical failure of his development from infantile dependency to adult independence.*

I am going to be critical of my therapist again. She keeps talking to me about my relationship with her — but her comments are not analytical. She just talks like any non-analytical therapist would talk about a patient’s relationship with a therapist.

When I complain about this, she says: “I am thinking about your internal objects.” I seriously doubt she is.

I talk about Dr. P with her and she has no insight at all. And yet the literature (which I cite in this post) talks about how my obsession with Dr. P can grow out of my internal objects. She doesn’t seem to know enough about Klein to make any meaningful observations about the object relations implications of my conscious obsession.

In my opinion, she’s a social worker who thinks she’s an analyst. “I am a psychoanalyst,” as she likes to repeat to me. But she isn’t an analyst. I can see that in her work.
She is unable to integrate all the fragments that she knows about me from an object relations perspective. She cannot think about how my obsession with Dr. P from an internal objects perspective relates to the internal object relations that account for my scapegoating in groups. All these things must be related — they are the internal objects of a single mind, namely mine.

Does my therapist have a grandiose sense of her abilities? Is that a character issue in her that should be obvious to a training analyst? I don’t know.

“I am thinking about your internal objects.” If she were really thinking about my internal objects she would be able to see how my concrete relations and fantasies about the real world all relate to each other at an abstract level. That’s not happening. So when I talk about Dr. P, all she sees is that I am talking about my concrete obsession with Dr. P. And when I say coworkers thought I was a homicidal maniac (responding to my internal objects—fear of engulfment and loss of identity) she simply has the idea that my coworkers were harsh with me. But all these concrete issues relate to my relationship with my mother at an internal objects level. How does my fear of engulfment relate to my “memorial search for my internal idealized love object.”

November 11, 2019

In a recent blog post I pointed out the following coincidence concerning my therapist. I wondered if it was a one-off or whether it had psychological meaning as it relates to my therapist’s personality:

I noticed something peculiar with my therapist. On two occasions she has used the F word. But it’s always in a quotation of something that someone else has said. For example, in her anecdote about Harold Searles, she quoted Searles’ statement to a patient: “Who the fuck cares if you never say another word?” The patient, writing about the experience states: “I was mute. I believe he [Searles] knew I was encumbered by a desperate idealizing transference, and knew he needed to challenge it: “May I share a thought I had a few minutes ago?” I said yes, grateful he would be doing some talking. He answered: “I’d thought, ‘Who the fuck cares if you never say another word?’”

I can see now that this probably has meaning. She did the same thing when she called me a freak. She put the word “freak” within a quote of something that somebody else had said about me. A previous therapist had called me a freak and my current therapist said: “Didn’t your previous call you a freak?”
The backstory is that the patient was seeing the therapist twice per week and had several times asked to see her only once per week. The therapist repeatedly insisted that the patient see her twice a week and devalued him when he requested a reduction in scheduled hours. “Your previous therapist said you were a freak,” she said. “Didn’t you tell me he said you were a freak?”

I’ve come to see this behavior for what it is. These are instances of the therapist’s mendacity. In using these quotations, she is doing two things simultaneously. She is adopting someone else’s objectionable word, but simultaneously she is disavowing her use of the word — putting the word in somebody else’s mouth.

I’ve talked about her mendacity previously. She tries to cancel things out.

She gets to have her cake and eat it too.

November 8, 2019

DR. CALIGOR: Psychoanalysis is highly unstructured treatment, where the technique focuses on transference analysis. The patient’s job is to free associate and the interventions of the analyst focus on the analysis of resistance and, particularly, on the resistance to transference. Analysis is, in my mind, a focal treatment, because the focus is on the transference most the time. So we teach our trainees basically to work with the transference. One can think of the entire treatment frame and technique in psychoanalysis as developed expressly to provoke “regression,” the emergence of unconscious mental processes, focused in the transference, in a patient who is very well defended against such regression and very rigid. And how do you get transference? With a borderline patient, you get too much transference. With a neurotic patient the transference does not emerge very readily. So to be able to work actively and consistently in the transference in the therapy of a neurotic patient you need frequency, long duration of treatment, the analysis of the resistance to transference by a therapist. Use of the couch and the relative inactivity of the therapist also facilitate the emergence of transference; the patient cannot use interpersonal cures to automatically correct transference/based distortions as s/he does in her usual interactions with others. This is psychoanalysis. In contrast, in the non-analytic treatment of persons with higher level character pathology the sessions are less frequent, the therapist is more active and, in fact, the focus in not on the transference, because in a twice a week treatment with a neurotic patient, the affectively dominant issue is often not in the relationship between the therapist and the patient. If the transference is a resistance, if it is a negative transference, and if it
becomes a conscious focus of the patient’s experience in the session, we do focus on it, but often, what is more meaningful for the patient in the moment is what’s going on outside the transference. In both forms of treatment clinical focus is on the dominant object relations; in psychoanalysis we gain access to dominant object relations through transference analysis, whereas in DPHP (Dynamic Psychotherapy for Higher Level Personality Pathology) often through the external relationships.

Dr. Caligor points out an important fact: “Psychoanalysis is designed to work in the transference with neurotic patients, who are not very transference ready, and the technique “Transference Focused Psychotherapy” is designed to work with borderline patients / who are too transference ready.” I am not transference ready. And I doubt that I even have a transference relationship with my current therapist. I am concerned about the extent to which my therapist’s patient pool is made up of patients with lower level character pathology who are in fact “transference prone.” Is my therapist even able to recognize a patient who is not transference ready? Is she aware of the clinical context that I require to even develop a meaningful transference? I have my doubts.

Comparison with my work with my therapist are in order.

1. Dr. Caligor emphasizes the patient’s freedom to free associate. I am not permitted to free associate. My therapist calls free association “getting lost in the woods.”

2. My therapist never addresses resistance in any way. She never addresses resistance to the transference.

3. Dr. Caligor emphasizes the need for the patient to regress to open up access to unconscious mental processes. My therapist shows a strong resistance to patient regression and unconscious mental processes. She talks about the ever-present need to bring the “observing ego” to bear on the material. My therapist emphasizes conscious, deliberate thought process and shuns regression. In my opinion that’s fine in non-analytical therapy, but in no way is that analytic.

4. Dr. Caligor emphasizes “analytic abstinence” (analyst inactivity) as one vehicle to elicit transference. She recognizes that transference takes time to develop and seems to implicitly believe (unlike Kleinians) that not every patient reaction to the therapist or “analyst” constitutes transference. My therapist has assumed from the beginning that everything I talk about is a symbolic reference to her. (In the nonclinical setting,
an individual who assumes that everyone’s random statements refer to him would be diagnosed with paranoid “ideas of reference.”) If I talk about my feelings about the summer solstice, for example, that, in my therapist’s mind is a reference to her and the work (“Your reference to the summer solstice means you want your therapy sessions to be longer.”)

5. Dr. Caligor points out that in twice per week patients, the emphasis is not on the transference. I was in twice-per week therapy with my therapist, yet my therapist maintained that the therapy was all about the “transference.”

In summary, in my own current treatment there is (1) no free association; (2) no resistance interpretation; (3) no regression; and (4) no analytic abstinence. And, as I say, that’s fine. In my opinion, she’s an outstanding therapist. But her work is not analytical — it seems to be strongly supportive with borrowings from analytic theory. I’m sure that helps many people. But I specifically signed up with her because she advertises herself as a psychoanalyst. She even has a picture of Melanie Klein on her webpage! I think that’s false advertising.

This is what I find particularly galling — she insistently maintains that our work is analytical. When I tell her I don’t think her work is analytical she will say, “It is analytical because our work is all about our relationship, your transference relationship with me.” And she will repeatedly say “I am the analyst” to emphasize her power over me. I am moved to inquire: On what planet does she spend most of her time?

November 8, 2019

I have had continuing difficulties with my therapist centering on her determined preoccupation with interpreting everything I say and do as relating to her. Whatever I talk about, in her mind, I am symbolically talking about her.

A research study from Penn State shows that with avoidant patients — I have avoidant, introjective pathology — therapists pushing their transference interpretations on the patient only serves to turn the patient off and actually undermine the therapy relationship.

This is the nail in the coffin: A concrete finding that my therapist’s technique, while useful with anaclitic patients, is counterproductive with avoid and (and introjective)
patients. I need to see somebody like Dr. Palombo. He didn’t push transference interpretations on me.

*The authors state: “The results suggest that therapists who persisted with interpretations had more hostile interactions with patients and had patients who reacted with less warmth than therapists who used interpretations more judiciously.”*

And when I complain, she turns me into the aggressor: “You don’t want me to have my own mind. You don’t want me to have my own thoughts.” No, I just want you to stop talking!!

**November 7, 2019**

*This is from Ken Levy’s paper, “Transference, Transference Interpretations, and Transference-Focused Psychotherapies.”*

*Ken Levy is a Penn State psychologist and a friend of Dr. Caligor’s.*

**Therapist.** I am not completely sure of this but I think something just happened between us that might be useful for us to explore. I think it is worth our considering (patient nods agreement). I noticed that you became tense and that your voice sounded angry in response to the question I just asked you. Is that consistent with what you noticed

**Patient.** (pause, patient appears to be thinking). Yeah, I guess (offered in a somewhat calmer manner but still a bit annoyed and possibly acquiescing).

**Therapist.** Well, from the way you just said that, I am wondering if a part of you agrees with what I just pointed out, a part that on reflecting on your experience might have noticed that you seemed tense and annoyed, but that another part of you also might be having a reaction to what I said and that part is not fully buying what I said?

**Patient.** No, no I realize I am tense and feeling angry. But not [angry] at you.

**Therapist.** Well, I think what is happening right now in discussing your reactions to my observation is related to the larger comment that I was going to make (patient
now looks attentive and interested). Based on your reactions to what I said just before, that is, my earlier question, it seems to me that you experienced my asking it [the question] as an attack on you—just like you might have experienced my observation as a mini-attack. It is as if in asking the question, I was trying to belittle you. Do you think that sounds accurate or am I off the mark?

**Patient.** No that sounds right. It is hard to not hear it that way.

**Therapist.** Well, that is what I think would be useful for us to explore. Does it have to be heard that way or is there another way of hearing it? It seems like it is difficult for you to imagine that my question was an indication of concern and that I asked it to better understand your experience. (Pause), I think your reaction would be justified if I meant my comment as an attack, but on the other hand, if I did not, and if I asked it as sign of concern—and I do not mean this as a criticism, but I think it is important that we understand your reaction—then hearing it this way, you might be robbing yourself of a moment in which you could feel as if someone was on your side and trying to be helpful. And, this dynamic reminds me of what you were telling me about your experience of your coworkers in which you feel that they do not have your back and instead are trying to provoke you and undermine you.

**Patient.** Well, I am sure that they are [being provocative and undermining].

**Therapist.** Maybe so, but the question arises if your perception of those events, which is consistent with what we have discussed as your experience with your father, who you saw as critical, harsh, and competitive with you, is influencing how you are experiencing me, right now, here in this room, so that a question offered out of concern is similarly experienced as an attack and belittling.

*Compare the above with the following. The following is an accurate description of a session I had just a brief time ago.*

**Patient enters the therapist’s office carrying a book. It is a copy of the Psychoanalytic Study of the Child that includes a paper by Sidney Blatt that discusses anaclitic and introjective pathology. The paper is titled, “Levels of object representation in anaclitic and introjective depression.”**

**Patient.** I wonder what we are doing here. To me, you seem very interpersonally oriented in your work. And I wonder if that addresses my problems. You know, I
struggle with issues that are not specifically interpersonal. I am so self-critical. It goes on all the time in my head. It never stops. I am a perfectionist. I am obsessed with performance and achievement. It was important to me to write my books. I look on that as an achievement. I don’t think about social relations. About doing social stuff. I am preoccupied with my inner world. And I don’t think your work addresses that. Everything here relates to me and other people. I remember back in June talking about my sense of elation about the upcoming summer solstice and you said [with certainty], “You are concerned about the length of our sessions. You talk about the solstice because you would like your sessions to be longer.” And I said, “What I was thinking about was the idea of time standing still— and the idea of the Faustian moment, the Augenblick [the therapist is German-born] — a moment of bliss that would last forever.” I didn’t think my comments about the solstice related to you and me. I’m always thinking about me, not about you and me. I don’t see the world in those terms. Those relational terms. With me everything centers on my inner world. I was reading a paper by Sidney Blatt. He talks about anaclitic and introjective personalities. Based on his description I think I have a classic introjective personality. Let me read you just one paragraph. It’s the first paragraph of a section that talks about introjective personalities. That’s all I’ll read. I don’t think we ever touch on the things that he talks about. The things that he talks about are the things that relate to me specifically, I think. These particular psychological issues. Here, this is what he said:

Patient proceeds to read the paragraph and becomes angry as he points out every issue that he feels the therapist has not addressed in the therapy. The patient offers an angry and detailed lecture, based on psychoanalytic theory, concerning the therapist’s work. He seems determined to make her feel incompetent.

The therapist responds angrily. She proceeds to talk about how the patient picks fights with her, how he has been mean to her, how he wants to have his own way, how he acts as if he is the only person in the room. There is a personal quality to the therapist’s angry comments. She does not address how the patient’s presentation relates back to his introjective pathology: namely, the patient’s projection of angry internal objects onto the therapist. The therapist does not address the patient’s obvious feelings of frustration about the therapist’s technique and theoretical orientation and his feeling that the therapist seems determined to force an object relations orientation onto him rooted in Klein – Betty Joseph – and Bion that the patient feels does not address his needs. The backstory is that the patient was seeing the therapist twice per week and had several times asked to see her only once per week. The therapist repeatedly insisted that the patient see her
twice a week and devalued him when he requested a reduction in scheduled hours. “Your previous therapist said you were a freak,” she said. “Didn’t you tell he me he said you were a freak?”

The therapist proceeds to make an attempt at a transference interpretation as follows—

THERAPIST: The way you were mean to me probably accounts for why you had problems with your coworkers.

In fact, the patient was an outstanding employee who was a target of workplace mobbing. His supervisor was a known racist. The mobbing literature cites traits found in many mobbing victims that accounts for their interpersonal difficulties.

These traits appear to apply to the patient: “Those targeted are often people who threaten the organizational stasis; and, the most common characteristics identified as reasons for being targeted are refusing to be subservient (58%), superior competence and skill (56%), positive attitude and being liked (49%), and honesty (46%) (Namie & Namie).” Sloan, L.M., et al., “A Story to Tell: Bullying and Mobbing in the Workplace.” Adams and Field believe that mobbing is typically found in work environments that have poorly organised production or working methods and incapable or inattentive management and that mobbing victims are usually “exceptional individuals who demonstrated intelligence, competence, creativity, integrity, accomplishment and dedication.” The patient had been by described by his employer as being “as close to the perfect employee as it is possible to get” and an individual who “inspired his coworkers.”

It is striking that the “transference” issue here is actually a counter-transference issue. The therapist, in her anger, identifies with those persons in the patient’s environment who had abused him. In this way the therapist rationalizes her anger toward the patient and rationalizes the behavior of his coworkers toward him. The therapist also failed to address the authority struggle here. Previously, she stated several times, “I am the analyst,” seeming to assert her authority but she has never bothered to explore the psychological meaning of the patient’s “refusal to be subservient” in the workplace and in therapy.

Notice how the fictional therapist presented by Levy offers his ideas as tentative (“I am wondering,” “Do you think that sounds accurate or am I off the mark?”)
My therapist states her observations with certainty. When I said to her, “I think you speak with way too much certainty,” she replied, “Of course I speak with certainty. I am a psychoanalyst!”

APPENDIX: In Memory of Bloomsday – June 16, 2019 – A Manic Train of Thought Inspired by the Summer Solstice

The entrance to Paradise was blocked by a Mayflower moving truck while a veritable horde of maddeningly-inspired and passionately-overwrought glowworms crawled languidly across Pennsylvania Avenue, where, I might add, the traffic killed us on the way to the Capitol, and proclaimed the coming of the summer solstice while we beheld the mighty monument to officious official records housed in the National Archives where the forged and unsettlingly-irreverent papers of Warren G. Harding had been befittingly kept since he dropped dead unceremoniously, in ignominy, in 1923, under a striped red and gold canvas canopy on the White House South Lawn after the President — oblivious to Florence’s cries of treachery — had been discovered in flagrante delicto with the wife of the Academy’s Treasurer by the executive chef, himself a native of Paris who had been raised in the East End of London and who was attired in a dark blue uniform adorned with bright red epaulets, military regalia that had always been worn by members of the French Foreign Legion, and, who, holding in his right hand a pan of eggs and sausages (what else?) burned at the outer edges by the searing heat of the Mansion’s out-of-date kitchen appliances, would later be heard shouting at members of Parliament to
vote in favor of a hard Brexit that would free Britain from the atrocious shackles of 40 years of humiliating servitude in the European Union notwithstanding trade agreements made with the Red Chinese Communists after the Tiananmen Square massacre, which would stabilize the price of Brazilian bananas on the open market, but before Tibet had declared Independence and assumed its rightful place in the legion of Asian nation states bent on conquering the Antarctic and enslaving the local endangered penguin population that scammed among the ice fragments and flows in the face of the coming winter for which 50 million years of evolution had prepared them, so I had learned one night while dining on black caviar and watching a vintage big screen TV in a rented house in Brentwood, California oblivious to the possibility that the Big One, feared for decades by longtime residents of Southern California, might trigger a huge stock market crash, with bond prices falling to their lowest level since the year 1567 when Venetian authorities had begun to dutifully keep records of the ebb and flow of the flooding Adriatic Sea, and, yes, it now occurs to me, Cleopatra had lost her ill-gotten fortune “on or about” the Ides of March, several millenia before, when the Queen of the Nile had made her way to Rome, with Caesar’s protection, and was paraded around the Capitoline Hill and marched through the Arch of Titus that served as a mausoleum for the mighty Emperor himself for whom Cleo — as she was called by intimates (not to mention brazenly disrespectful subjects of a breakaway province of southern Egypt) — harbored a special affection in the glory days of Rome’s rule of the Mediterranean, before the Huns and the Ostrogoths had conquered Northern Italy in a stroke of military genius that was to insure the place of the barbaric Germanic tribes as the leading advocates for women’s rights and proponents of a Constitutional Amendment that would guarantee that midshipman on shore leave would not take advantage of loose women bent on earning a living wage, or torment lost dogs, whose dog tags clanged in the night air, on Broadway all the while waiting in line to see a debauched yet sanguine Annie sing a boringly-monotone performance of “The Sun Will Come Out Tomorrow” among a thousand other errands to be run while riding the A train to Queens or The Bronx or some such place that no decent housewife, if there even be decent housewives anymore, would ever espouse and, yea, recite in blessed solemnity under a white satin wedding chuppah (if I might be permitted this one instance of redundancy), with a reform rabbi chanting in Sephardic Hebrew the sacred commands delivered to Moses on Mount Sinai when the Law was declaimed by God to the ancient Hebrews notwithstanding their discomfort with medieval French conjugations and declensions that Mr. Boni had taught to the upper classes at Central High School after girls were admitted to the hallowed halls that had
educated the poor masses of boys educated on Green Street, or was it Spring Garden Street, in North Philadelphia and whose term ended in mid-June in time to greet the summer with a copy of Joyce’s Ulysses in one hand and a box of stolen condoms in the other, hitchhiking all the way to the Schuylkill River to get laid under under the mid-summer stars on the banks of the West River Drive in the days before the much anticipated exhibit of sculpted characters from Dante’s Inferno at the Rodin Museum left us in awe of the mastery of bronze and marble craftsmen as well as the finer aspects of 20th-century Irish literature.

**November 6, 2019**

Just can’t get into this. I suppose this technique could be useful with an experienced analyst, but in the hands of my inexperienced therapist it comes off feeling like talking to a high school counselor.

My therapist fails to address one simple question: How does her technique, regardless of its validity, address my personality problems? She is unable to answer that question.

The Bionian technique that Dr. Grotstein describes focuses the work on the “here and now” and on the ongoing moment-to-moment relationship with the therapist. Bion believed that you can’t analyze the past. The past is past. You can only analyze the past as re-presented in the present, with the therapist.

But there is a bitter irony about this as it relates to my therapist. If I were to walk into my therapist’s office, sit down, and talk about my feelings in there here and now about her, I would say something along the following lines:

I don’t know. I feel so frustrated here. I don’t feel we’re getting at important issues. I feel that there is something so shallow and superficial about your work. I just don’t think like you. We have different values. You know, I love history. I loved my history courses in school. I love biography. I love reading about people, their whole history, going back into the past. That’s my value system. And it carries over into therapy. I have an interest in my own past and how it replays in the present. To me the here and now is drained of meaning if you don’t see the past in the present, which in itself requires a deep appreciation of the past: the things done, as they say in the law. I can’t let go of those values in this context, in
the therapy context. I carry these values with me wherever I go. That’s my identity. A person who places value on understanding the historical development of things. We don’t seem to do that here. And then, there’s the feelings I have about you and your work. I think your work is amateurish. It’s shallow. And it’s uniformed. Then, quite frankly, I don’t really understand it. I have no idea what you are doing and it bothers me. And I have asked you several times to explain your work and you just sit silently in your chair. When I was seeing Dr. Palombo, I thought I could see what he was doing. I thought I understood what he was doing. And I valued that style of work. Yes, I valued it. I understood it. I felt I could benefit from it. I don’t have those feelings here. I am just confused and frustrated here. I feel that something foreign is being forced on me against my will. I feel so engulfed by meaninglessness here. Your work is meaningless to me.

And how would my therapist respond to that narrative that is a cognizable Bionian narrative? She would get angry and say I was picking fights with her and that I was destroying meaning. That’s all. That’s the irony. The fact that my therapist doesn’t have the ego strength to tolerate the full implications of her theoretical orientation. I have the sense that she needs to be admired and confirmed. If a therapist needs to be admired and confirmed by her patients, how can she ever deal with a patient’s negative projections that are rooted in his introjective pathology? How can she work with the negative transference. One wonders.

**November 6, 2019**

*If your aim is to make mushroom soup, a person needs to “get lost in the woods” to find the wild mushrooms. How do you make mushroom soup without the mushrooms?*

The French psychoanalyst Ren Roussillon clearly shows that transference interpretation is impossible without free association. The two components of psychoanalysis go hand in hand. This is a rebuttal to my therapist who thinks that transference is the bedrock of analysis and that free association is dispensable. Transference work is not simply looking at the relationship between analyst and patient, as my therapist seems to think. It is applying knowledge gained from that relationship to extratransferential issues to aid in understanding those extratransferential issues: the patient’s childhood relationships, intrapsychic functioning, and adult relationships. These extra-transferential matters are the “wild mushrooms” that are gathered through the patient’s free associations. The transference is the mushroom soup. In order to do transference work you need to “get lost in the woods of associations” to gather material to which the transference
knowledge is applied. I still maintain that my therapist's work is not analytical and that she is deluded when she says it is. She is simply looking at my relationship with her.

Roussillon states: “The fundamental feature of the psychoanalytic method involves two closely-linked aspects: the reference to the transference, a precondition for any attempt at interpretation according to Freud, and the associativity of mental functioning as evidenced in the rule of free association.”

That is, free association and transference are two indispensable components in a system, namely, psychoanalysis.

November 6, 2019

I found this fascinating. The fact that my therapist is a Kleinian; she shows a strong resistance to free association (which she has termed “getting lost in the woods”); and her absolute emphasis on the “here and now”. What Christopher Bollas seems to be saying is that it’s no mere accident that my therapist disdains free association and that, in fact, she shows an intense resistance to free association. That’s what I suspected all along!! I could see that!! I could see what she was doing!! This explains that nutty thing she said at the outset when I said I preferred more free association and she said, “Free association can lead to intellectualization.” That was simply a dismissive rationalization. This is a rebuttal of my therapist’s work.


I should have been a police detective. I could smell what was going on with her.

It’s a paper by the psychoanalyst, Christopher Bollas. He’s a top notch guy.

On transference interpretation as a resistance to free association.

Article in Psyche 60(9-10):932-947 · September 2006 with 83 Reads

Abstract
One of Freud’s earliest concepts of transference was his discovery that for an unconscious idea to enter consciousness it must connect to an already existent idea that is within the preconscious. This connection is a transfer. Building on this particular model of transference Freud’s invention of the analytical relationship facilitates the movement of unconscious ideas into consciousness in a very particular manner. With the free associating analysand and the evenly suspended analyst—which this essay terms, “The Freudian Pair”-Freud found a way for unconscious meanings to be communicated from the analysand to the analyst without all the contents ever entering consciousness. This remarkable and revolutionary discovery, a new form of object relation, has unfortunately been marginalized by Freud’s more common definition of transference as the transfer of the analysand’s feelings and thoughts about the analyst into sessional material and behavior. Indeed this essay argues that the militant use of this perspective has become a resistance to Freud’s more profound first definition—which is specific to psychoanalysis—and in the case of the so-called “here and now” transference interpretation (adopted first by the British School of psychoanalysis—i.e., the Kleinians) it has become a paranoid system of thought that is indistinguishable from a formal idea of reference. The implications of this development on the Freudian Pair are discussed.

November 6, 2019

Under the Federal Rules of Evidence the court may exclude relevant evidence if its probative value is substantially outweighed by a danger of one or more of the following: unfair prejudice, confusing the issues, misleading the jury, undue delay, wasting time, or needlessly presenting cumulative evidence.

I am reminded of an issue in psychoanalytic technique. My therapist often tells me anecdotes that have nothing to do with me. She talks to me about Melanie Klein, Betty Joseph, Karl Abraham, Edna O’Shaughnessy, Harold Searles — and other psychoanalysts. I generally have no idea how her anecdotes have anything to do with what I am talking about. She fails to see that the minimal or nonexistent importance of the anecdote disrupts my thinking. And she fails to weigh in her mind: “Is this anecdote of a value that it justifies me sharing it with the patient and possibly disrupting the patient’s train of thoughts.”

She’s an amateur. It’s also her narcissism. She thinks everything she has to say is of great value. I sometimes wonder something about her. Is it possible she was a precocious child (she’s highly intelligent) and that her parents doted on her because of her intellect. She loved going to daddy and telling him things and getting the response, “You are such a smart little girl! You are the smartest little girl in the world.” I wonder. That would be more countertransference.
November 5, 2019

BACKGROUND:

I had sent an email to my therapist advising of my formal decision to see her once a week instead of twice a week. At this session, she finally agreed to that schedule. I had the subjective sense that she seemed chastened by what I wrote about her, but she didn’t seem irritated or angry. She said that what I wrote was basically a repetition of my oral comments at our sessions.

I pick up a hidden unconscious narrative or agenda in my therapist. At one point today my therapist told me about a therapy interaction between Betty Joseph and one of her patients. Betty Joseph was a leading Kleinian. I thought that was strange. Then, don’t you know, at a later point in the session she told me about a therapy interaction between Harold Searles and one of his patients. Two parallel anecdotes at different points in the session. Was that a meaningless coincidence?

And I asked her: “What does that anecdote about Harold Searles’ patient have to do with me?” She said: “That’s my subjective thinking.” She couldn’t explain any connection to what I was talking about but because it was her association to what I was saying she thought it was important to tell me. Why? I was thinking: “subjective thinking or countertransference?”

I really think she’s getting her psychological needs met in her work with me.

Be that as it may.

I noticed something peculiar with my therapist. On two occasions she has used the F word. But it’s always in a quotation of something that someone else has said. For example, in her anecdote about Harold Searles, she quoted Searles’ statement to a patient: “Who the fuck cares if you never say another word?” The patient, writing about the experience states: “I was mute. I believe he [Searles] knew I was encumbered by a desperate idealizing transference, and knew he needed to challenge it: “May I share a thought I had a few minutes ago?” I said yes, grateful he
would be doing some talking. He answered: “I’d thought, ‘Who the fuck cares if you never say another word?’”

Did my therapist’s reference to this material relate to my being sick of hearing her talking and my complaining that she talks too much?

In any event, that’s the second time she has used the F word — and each time it was in a quotation. I swear to God, I sometimes get the sense that she thinks she is in analysis with me — and she free associates to me. That’s all counter-transference. I wonder who is the mentally healthy person in the room!

**November 3, 2019**

**The Scope of Analyzability**

In a previous blog post from the year 2015 I talked about my ideal model of psychotherapy in which the communications and behaviors of the patient in a therapy session should be seen as comparable to the *res gestae* (“the things done”) of a crime — that is, the planning and execution of a crime terminating when the suspect has achieved a position of relative safety from law enforcement. I would define the *res gestae* of psychotherapy as the totality of the patient’s statements and behaviors in the 50-minute hour. I argued that just as there is no right way to commit a murder, there is — to some reasonable extent — no right way to do therapy.

My current therapist talks about “the work” — suggesting that certain parts of my interaction with her are analytically appropriate, but other aspects of my interactions — such as my criticizing her or perhaps my self-analysis — are not part of “the work.” She appears to view my criticism of her as non-analyzable.

That’s patently false, I must say, in view of the fact that my negative comments about her constitute “negative transference” which is analyzable. Indeed, Melanie Klein said that the analyst must first address the patient’s negative transference — if it exists — before a healthy positive transference can even emerge. Sidney Blatt says a similar thing about patients with introjective depression. Blatt writes: “Therapists need to be aware of the ways in which [those] patients

[with malevolent, harsh, and punitive representations of significant]
others] perceive them early in the course of treatment, of how such perceptions are often tied to patients’ internal representations of self and others, and how these representations can actively limit the capacity of patients to participate in the therapeutic alliance.” Thus, a patient’s criticisms or other negative reactions to the analyst are not “non work” — they are the grist of the analytic mill. Analyzing the negative transference is the work.

I draw a comparison to the work of the police detective. See, Yang, A., “Psychoanalysis and detective fiction: a tale of Freud and criminal storytelling.” In crime scene analysis of, say, a murder, every piece of evidence left by the perpetrator tells us something about the crime and the identity of the perpetrator. In crime scene analysis any possible evidence of the perpetrator’s behavior is the work of the criminalist and the behavioral analyst. For example, if there is evidence that the perpetrator ate an apple at the crime scene — that has meaning. The criminalist does not say, “Well, the subject was hungry, but we can ignore that because it had nothing to do with the crime.” (Why would somebody who breaks into a house and murders the occupant eat an apple at the crime scene? In the days before DNA analysis the apple core might shed no light on the subject’s identity, but an FBI profiler might find that behavior significant.)

My therapist seems to have the idea that an analyst can focus solely on certain things and ignore other things — the things she does not consider “the work.” Does my therapist’s ideas about “the work” point to the limitations of her analytical skills? When she talks about “the work” is she saying: “When you talk about certain things, I don’t have the skills to work with such material. You are, thereby, exposing my professional limitations, which I experience as a narcissistic injury. Therefore you are doing something bad (making me feel bad), because your behavior injures my idealized self-image as a superior analyst.” One wonders.

Here’s what I wrote in 2015 in my previous blog post:

Under the law there is no right way to commit a crime. Conversely, under the law there is no wrong way to commit a crime. Sometimes the criminal leaves fingerprints or DNA. Maybe he leaves no evidence relating to his personal identity. Sometimes criminals wipe their fingerprints clean. Under the law a criminal is free to commit the crime as he wishes. Only the crime itself is illegal. There is no charge: “Criminal Failure to leave DNA Evidence.” There is no charge: “Willful concealment or destruction of fingerprints at the crime scene.” The criminalist is not permitted to blame the criminal for the criminalist’s inability to provide the prosecutor with evidence for trial. That’s not how our system works. The criminalist has to work with the
evidence he has, the evidence he is able to find. Everything about the crime scene, as the
criminal leaves it, points to a particular psychology, mindset and sophistication of the criminal.

Perhaps it would be useful if psychiatrists looked at a patient as a crime scene. Perhaps they
should see themselves as a criminalists. Everything the patient says or doesn’t say in a clinical
session suggests things about the patient’s disorder and psychology. The problem is psychiatrists
don’t see it that way. They don’t want to see it that way, because, then, psychiatrists would
have to take responsibility. They want to badger a patient with accusations such as, “You
don’t talk about your feelings! I can’t help you if you don’t talk about your feelings.” Or “You
intellectualize! You shouldn’t intellectualize.” Would a criminalist say, “The criminal had a
duty to leave fingerprints. Apparently, he wiped them clean! The bastard!!” But that’s what
psychiatrists do. It’s as if psychiatrists demand that the patient lay everything out neatly for
them to evaluate. In no other medical specialty could a doctor get away with blaming the
patient, say, in an instance where a tumor was difficult to surgically remove or an immune
response never materialized. If a patient doesn’t talk about feelings, that’s a symptom. If a
patient intellectualizes that’s a symptom. If the psychiatrist knew what he was doing he would
understand the meaning of aspects of the patient’s personality that caused him to relate to the
therapist as he does.

But all of this is actually a prelude to what I wish to say. I am intrigued by the fact
that in dysfunctional families, the so-called “identified patient” is blamed by other
family members for the family’s problems. I was particularly struck by one theme in a
family therapy article, namely, the family’s emphasis on the patient’s “deviation from
normality.” “Our kid just isn’t normal. He doesn’t act like other kids. There’s
something wrong with him.” The authors write: “[W]e will highlight how family
members, excluding the identified patient, seem to engage in attributing blame for
their distress on him/her by making an appeal to a discourse of deviation from
normality in their attempt to define the problem.” Discussing the mother in one
family the authors write: “In this way, she manages both to construct an image of a
united couple, a non-problematic family and also exonerates blame from the two
parents as it is the uncontested son’s abnormality which accounts for everything.”

Do these observations apply to my current therapy situation? Is my therapist saying:
“When you talk about certain things, such as, your repeated criticisms of me, you are
deviating from the behavior of my other patients. You are deviating from normal.
You introduce material that lies outside “the work.” Other patients try to stick to
“the work.” You are thereby impeding my ability to work with you, help you, and you
are impairing your own improvement — and ultimately you are not fulfilling your
role, which is to confirm my sense of myself as an outstanding therapist. You are bad!!"

In the dysfunctional family, in which there is a high level of individual narcissism, the problem child tarnishes the family’s shared self-image as the ideal family. See, e.g., Brodey, W., “On the Dynamics of Narcissism” (“The family relationships were characterized by narcissistic intensity (extreme at times) and its corollary, abandonment fears. Family member’s relationships were reciprocal image relationships among individuals who joined in externalizing each other’s projections.”)

Perhaps in my therapist’s mind, my “uncontested abnormality” — my deviation from the typical therapy patient (remember my therapist said to me at one point, “You try to be your own analyst,” that is, “you are deviating from normal”) — accounts for everything wrong with my therapy. In this way my therapist constructs an image of herself as a superior analyst and exonerates herself of any professional limitations.

One wonders.

Keep in mind, a criminal is bad because of the crime he commits, and not because he impairs the work of the criminalist.

A few words about a patient’s self-analysis. Bion understood that when a patient tries to be his own analyst, that’s not bad act of “non work.” It is simply a behavior that is analyzable. What does it mean that this patient tries to be his own analyst?

Freud tried to be his own analyst. Didier Anzieu looked for psychological meaning in that activity.

Anzieu’s book, Freud’s Self-Analysis is a detailed study of Freud’s early life as mirrored in the dreams he chose to recount and analyze in The Interpretation of Dreams. From a Kleinian viewpoint, Anzieu considered Freud’s “elaboration of psychoanalytic theory . . . corresponded to a setting up of obsessional defenses against depressive anxiety”—emphasizing Freud’s need to ‘defend himself against it through such a degree of intellectualization.”

November 3, 2019
Not infrequently my therapist will offer interpretations that are not directly based on the evidence of my material. Rather, the interpretations are based on my therapist’s own associations and intuitions. These interpretations can be valid. Interpretations based on analyst association and intuition are known as “inspired interpretations.”

Two examples: On one occasion my therapist associated my material to the story of Cain and Abel. I didn’t find the interpretation useful, but simply bizarre.

On a second occasion, I made a simple reference to the playwright Henrik Ibsen and my therapist associated to the play, *The Wild Duck*, specifically the incident involving the character Hedvig Ekdal fatally shooting herself. Again, I thought my therapist’s comment was bizarre and projective.

It is recognized that “inspired interpretations” should only be used by experienced analysts. “Inspired interpretations can only be used by experienced psychotherapists.” But my therapist is an analyst-in-training, and not an experienced analyst.

Is my therapist’s use of a specialized technique that is reserved for highly experienced analysts a sign of her grandiosity? Does my therapist’s work reflect improper training by the Washington-Baltimore Psychoanalysis Center?

From: *Teaching Meltzer: Modes and Approaches* edited by Meg Harris Williams

*November 1, 2019*

What does it mean when a therapist does therapy as if she were opposing counsel in a lawsuit?

1. She is always right. Her way of seeing things is the only way.

2. When I repeat something she has said, her response is invariably: “You misunderstood what I said.” It’s like Trump’s defenders: “You misunderstood the President. When Mick Mulvaney said there was a quid pro quo, he didn’t mean there was a quid pro quo.” (I speak the English language. I know what I am hearing. Maybe I falsely construe some things, but I can’t *always* be wrong.)
3. Shows an absolute refusal to see things from my perspective. Of course, that’s what a lawyer does in a legal dispute. The lawyer’s client is always 100% right. There is no merit to the opposing side’s viewpoint.

4. Rationalizes everything no matter how the rationalizations are undercut by other statements and behaviors.

   Every time I say “My sense is that you . . .” — she will respond: “That’s your fantasy.”

5. Every time I criticize her, my criticism has no merit in her view. Plus, she will get angry and spout jargon.

   What does it mean when a therapist does therapy this way? It must mean something. You can dispute that this is actually happening, but my question is – what am I describing? What kind of therapist is this? What therapy technique is this? Is it a brainwashing technique?

November 1, 2019

Letter to Therapist:

In the past two therapy sessions I discussed my desire to see you one time per week instead of the current two times per week. This letter will advise you of my final decision to see you one time per week.

The following issues were a material factor in my decision. Listed below are issues that are commonly considered red flags in a psychotherapy relationship. I have discussed several of these issues with you, but did not receive a satisfactory response.

1. Therapist does not have sufficient and specific training to address your issues and/or attempts to treat problems outside the scope of the practice.

You have not explained how your relatedness-oriented technique – appropriate in the treatment of anaclitic depression – addresses my severely introjective personality. 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.

“It is recognized that it is important that therapists early adjust their orientation” –
based on the therapist’s assessment of whether the patient is primarily struggling
with relatedness problems (anaclitic depression) or self-related problems of guilt (self-
criticism) and identity-definition (introjective depression) – “in order to enhance
treatment outcomes.” Werbart, A. “Matching Patient and Therapist Anaclitic–
Introjective Personality Configurations Matters for Psychotherapy Outcomes.”

2. Therapist is not interested in the changes you want to make and your goals for therapy.
At the outset of my work with you I forwarded to you an email that listed significant
issues in my personality that needed to be addressed. You have never discussed these
issues with me. (See attached email). You have not explained how your work
addresses these issues.
3. **Therapist cannot or does not clearly define how they can help you to solve whatever issue or concern has brought you to therapy.**

I have asked you to address how your therapy technique addresses my introjective character pathology. You have failed to do so.

4. **Therapist does not seek consultation with other therapists.**

To the best of my knowledge you have not sought consultation on my case.

5. **Therapist knowingly or unknowingly gets personal psychological needs met at the expense of focusing on you and your therapy.**

It is my perception that you are determined to apply a therapy technique that satisfies your personal/professional needs, but that does not address my needs.

6. **Therapist cannot accept feedback or admit mistakes.**

You consistently become excessively defensive when I offer feedback. You will respond to my feedback with technical jargon. Examples: You will say that I am "attacking links," that I am "destroying knowledge," that I am "destroying meaning," that I am attacking you, that I am "picking fights" with you. On one occasion you said, "Your thinking is ideographic and not symbolic." I had no idea what you meant. You fail to appreciate that my negative comments, from a psychoanalytic perspective, constitute negative transference and that negative transference is analyzable. You further fail to see that my negative reaction to you reflects the harsh internal objects characteristic of introjective pathology.

7. **Therapist talks too much.**

I have repeatedly complained about the fact that you talk too much, that your dialogue with me tends to be conversational and pedagogic rather than exploratory and insight-driven. Many analysts say that they will adjust their contact with a patient to suit the needs of the patient. It is recognized that some patients need little contact.

8. **Therapist often speaks in complex “psychobabble” that leaves you confused.**
Again, you will respond to my feedback with technical jargon. Examples: You will say that I am "attacking links," that I am "destroying knowledge," that I am "destroying meaning." On one occasions you said, "Your thinking is ideographic and not symbolic." I had no idea what that meant.

9. Therapist focuses on thoughts and cognition at the exclusion of feelings and somatic experience.

You frequently focus on thinking, using Bionian concepts to the exclusion of my feelings and experiences. When I questioned your ability to work with free association, you said that it was important that I invoke the "observing ego." You ignore the fact that the very nature of free association is that it involves a regression to primary process thinking, and that it is recognized that free association requires a detachment from the observing ego.

10. Therapist tries to keep you in therapy against your will.

On several occasions I stated my desire to see you one time per week instead of twice a week. You coercively attempted to keep me in therapy two times per week. A recent session featured the following interaction:

At the beginning of the hour I told you I wanted to see you just once a week. You said nothing.

At the end of the hour, I said, “I will be seeing you once a week. I won’t be here Thursday.” You said, “Well, I’ll be here. I’ll be waiting for you whether you are here or not. That hour is reserved for you.” I said, “But I want to see you once a week.” You said, “Whether you are here or not I will be here waiting.” I said, “I’m afraid that if I don’t show up you will bill me.” You said, “You’re trying to make it about the money.” (You failed to state that you would not bill me for the hour.) Not wanting to get billed for the hour, I said I would show up on Thursday.

11. Therapist is contentious with you or frequently confrontational.

Again, you become excessively defensive when I offer feedback. You will respond to my feedback with technical jargon. Examples: You will say that I am "attacking links," that I am "destroying knowledge," that I am "destroying meaning," that I am attacking you, that I am "picking fights" with you. On one occasion you said, "Your thinking is ideographic and not symbolic." I had no idea what you meant. You fail to appreciate
that my negative comments, from a psychoanalytic perspective, constitute negative transference and that negative transference is analyzable.

At two sessions you said (quoting a previous therapist): "You are a freak" after I stated my desire to see you one time per week.

You further fail to see that my negative reaction to you reflects the harsh internal objects characteristic of introjective pathology.

“Perfectionistic [introjective] individuals have malevolent, harsh, and punitive representations of significant others. These malevolent representations interfere with self-critical perfectionist individuals’ interpersonal relations with significant others and with their therapists. In the course of therapy, perfectionist patients are likely to project aspects of these negative internal representations onto the therapist, thus actively disrupting the therapeutic alliance. Therapists need to be aware of the ways in which patients perceive them early in the course of treatment, of how such perceptions are often tied to patients’ internal representations of self and others, and how these representations can actively limit the capacity of patients to participate in the therapeutic alliance. Therapists need time, patience, openness, and sensitivity to interpersonal processes, both within the patient and within themselves, in order to address these obstacles.

In addition, therapists should be alert to ways in which patients actively generate a negative social environment outside of treatment. Perfectionism not only interferes with the therapeutic alliance, but it also interferes with patients’ establishing and maintaining supportive social relations. This interference with the therapeutic alliance, and with social relations generally, greatly limited patients’ ability to benefit from treatment (Shahar et al., 2001). This generation of a risk-related context by perfectionistic patients appears to derive from their negative representations of self and significant others, including their therapists. This process should be identified by the therapist as early as possible in order to prevent it from interfering with the patient’s ability to establish and maintain constructive relationships with the therapist and a wider social network.” Blatt, S.J. And Zuroff, D.C., “Anaclitic (Sociotropic) and Introjective (Autonomous) Dimensions.

12.Therapist doesn’t remember your interactions from one session to the next.
I am often dumbfounded at your inability to recall important issues that we have discussed.

13. Therapist does not empathize.
You consistently dismiss my discomfort with you. If I show appropriate anger about your failure to address my personality problems, you dismiss my feelings with statements such as, “You want to have your own way” or “You are mean to me” or “You don’t recognize that there is another person in the room” or “You don’t want me to have my own mind.” You submerge my justifiable distress with complaints about your own narcissistic injuries. The issue is my psychic pain, not yours.

14. Therapist does not ask your permission to use various psychotherapeutic techniques.
You frequently resort to Bionian theory. I did not consent to that. You apply relatedness-oriented techniques (directive, pedagogic, conversational) appropriate to the treatment of anaclitic depression that do not address my introjective character pathology. The literature recognizes that free association is crucial in the treatment of introjective pathology. See, e.g., Blatt, S.J. and Shahar, G., “Psychoanalysis—With Whom, for What, and How? Comparisons With Psychotherapy.”

It is problematic for a therapist to fail to support an introjective patient’s associative capacities and insist that her need to provide feedback makes the support of his associative capacities inappropriate. On one occasion when I used free association you dismissively said that I was “getting lost in the woods.” You fail to appreciate that “getting lost in the woods” is the treatment of choice for introjective patients.

Free association “was found to contribute significantly to the development of adaptive interpersonal capacities and to the reduction of maladaptive interpersonal tendencies, especially with more ruminative, self-reflective, introjective patients, possibly by extending their associative capacities. Limiting patients’ associative capacities will promote therapeutic change only in relationally-oriented patients; conversely, limiting patients’ associative capacities will impair therapeutic change in introjective patients. See Blatt and Shahar.

Emotionally detached, isolated, avoidant, and wary introjective patients, who tend to recall more family conflicts and who view relationships with others, including the
therapist, ‘as potentially hostile or rejecting’, found the exploratory emphasis in [free association] liberating and conducive to therapeutic change.” See Blatt and Shahar.

**October 28, 2019**

Letter to Therapist:

I have reached a decision to see you in once per week psychotherapy consultation rather than the current twice per week schedule.

I want to share with you my thoughts about our last session on October 24, 2019, which was critical to my decision to see you one time per week.

I began the session by talking about my perception that I was a scapegoat in my family. I spent some time talking about intrafamily abuse. I then mentioned that I sent a copy of my book *Psychotherapy Reflections* to a training/supervising analyst, Sandra Hershberg, M.D. I seemed to hit a raw nerve with that comment. You seemed to commandeer the remainder of the session by criticizing me about how I sent things out to people – books, letters, complaints – as if my actions were acting out. You told me that I was only hurting myself with these behaviors. *Well, yes!!* Notice the relationship between my opening comments at the session concerning intrafamily trauma and the behavior of acting out, as explained by Robert T. Muller, Ph.D., “Trauma and Dismissing (Avoidant) Attachment: Intervention Strategies in Individual Psychotherapy,” *Psychotherapy Theory, Research, Practice, Training* 46(1): 68-81 (2009).

Intrafamilial trauma is known to be associated with mental health-related challenges that place the individual at risk for the development of psychopathology. Yet, those trauma patients who are primarily dismissing (avoidant) of attachment also demonstrate significant defensiveness, along with a tendency to view themselves as independent, strong, and self-sufficient. Paradoxically, such patients present as highly help rejecting, despite concurrent expressions of need for treatment and high levels of symptomatic distress. . . . . These patients are often considered to be quite challenging, with difficulties arising from such issues as the complex nature of forming therapeutic alliances because of histories of interpersonal instability, emotional immaturity, and **behavioral acting out.**
Notice a significant process issue at the session. At the opening of the session I talked about my being the target of the aggression of others in my family. You largely ignored my victimization within my family – and proceeded to focus exclusively on my "victimizing" others, such as my last therapist against whom I filed an ethics complaint. You transformed victim into victimizer, or passive party into active party. Perhaps that transformation satisfied your own persecutory anxiety – your sense that I victimize you. Your observations about my interaction with third parties, which you seemed to depict as inappropriately aggressive, amounted to a self-serving discounting or minimization of the importance of trauma in my background. Your interaction with me ran directly counter to the recommendations of Robert T. Muller.

The challenge facing the therapist is to make active attempts to turn his or her attention toward trauma-related material; to listen for it, notice it, ask about it, and facilitate rather than avoid such painful topics. If not, the risk is that of replicating the rejecting response of the parent who reacts to the child’s abuse revelations by discounting or minimizing their importance.

You failed to “link” my opening comments about intrafamily trauma with my behavioral acting out in the form of sending out letters, complaints and books to people. This is yet another example of how you are unable to work with a patient’s free association. Through a patient’s "chain of ideas", or simply how the way people move from one topic to another reveals unconscious processes of thought. It was important at the session to note the importance of how I moved from my opening comments about intrafamily trauma to the issue of behavioral acting out in communicating with third parties. You failed to do that. You fragment many of the things I talk about. I talk about one subject – you will proceed to comment on that. I talk about a second subject and you will comment on the second subject. Analytic work requires holistic thinking by the analyst – a “putting together of the bits” to appreciate the whole object. Figuratively speaking, I will talk about sodium and you will comment on sodium. I then talk about chlorine and you will talk about chlorine. You never come to appreciate that what I am really talking about is neither sodium nor chlorine, but table salt.

Also, once again you seemed to depict my act of filing a complaint against my last therapist as a bad act – in defiance of the facts. We seem to be going around in circles. We covered these issues back in August. I explained in a letter that I gave to you at that time that it was the National Association of Social Workers that recommended that I file that complaint against my last therapist. The idea to file a
complaint did not originate with me. It appears that the facts cannot dislodge your need, rooted in fantasy, to view me as inappropriately aggressive.

In my letter about the session on August 2 I drew connections between my filing a complaint against my last therapist and my childhood experience of intrafamily trauma. So you were previously alerted to the need to “to listen for evidence of trauma, notice it, ask about it, and facilitate rather than avoid it” – or engage in unproductive moralizing about my behavior. I want to emphasize that it is an analytic truism that psychoanalysis is primarily efficacious due to entirely unconscious processes of change. You cannot efficaciously moralize about a patient’s behaviors; you can only interpret them. See Christopher Bollas, Free Association, The Evocative Object World and The Infinite Question.

In working with you I have the sense that I am writing on sand. The facts are continually effaced by the tide.

October 28, 2019

I began the session by talking about my perception that I was a scapegoat in my family. I spent some time talking about intrafamily abuse. I then mentioned that I sent a copy of my book Psychotherapy Reflections to a training/supervising analyst, Sandra Hershberg, M.D. I seemed to hit a raw nerve with that comment. My therapist commandeered the remainder of the session by criticizing me about how I sent things out to people — books and letters — as if my actions were acting out. She told me that I was only hurting myself with these behaviors. Well, yes!! Notice the relationship between my opening comments concerning intrafamily trauma and the behavior of acting out as explained by Robert Muller, Ph.D.

Intrafamilial trauma is known to be associated with mental health-related challenges that place the individual at risk for the development of psychopathology. Yet, those trauma patients who are primarily dismissing (avoidant) of attachment also demonstrate significant defensiveness, along with a tendency to view themselves as independent, strong, and self sufficient. Paradoxically, such patients present as highly help rejecting, despite concurrent expressions of need for treatment and high levels of symptomatic distress.

These patients are often considered to be quite challenging, with difficulties arising from such issues as the complex nature of forming therapeutic alliances because of histories of interpersonal instability, emotional immaturity, and behavioral acting out.
Notice a significant process issue at the session. At the opening of the session I talked about my being the target of the aggression of others in my family. The therapist largely ignored my victimization — and proceeded to focus exclusively on my “victimizing” others, such as my last therapist against whom I filed an ethics complaint. The therapist transformed victim into victimizer, or passive party into active party. Perhaps that transformation satisfied the therapist’s own persecutory anxiety — her sense that I victimize her. The therapist’s observations amounted to a self-serving discounting or minimization of the importance of trauma in my background. The therapist’s interaction runs directly counter to the recommendations of Robert Muller, Ph.D.

The challenge facing the therapist is to make active attempts to turn his or her attention toward trauma-related material; to listen for it, notice it, ask about it, and facilitate rather than avoid such painful topics. If not, the risk is that of replicating the rejecting response of the parent who reacts to the child’s abuse revelations by discounting or minimizing their importance.

So my therapist failed to link up my opening comments about intrafamily trauma with my behavioral acting out of sending out letters, complaints and books to people. This yet another example of how my therapist cannot work with free association. She fragments everything I talk about. I talk about one subject — she will proceed to comment on that. I talk about a second subject and my therapist will comment on the second subject. But she doesn’t put 2 and 2 together. The session is in fragments in her mind. She is not a holistic thinker. Figuratively speaking, I will talk about sodium and she will comment on sodium. I then talk about chlorine and she will talk about chlorine. She never gets to the point that she can see that what I am really talking about is table salt.

Also, my therapist once again depicted my filing a complaint against my last therapist as a bad act. We seem to be going around in circles. We covered these issues back in August. I explained that it was the National Association of Social Workers that recommended that I file that complaint against my last therapist. But my therapist has her fantasy image of me as “violent and destructive” and the facts will not dislodge her fantasy.

In my letter about the session on August 2 I drew connections between my filing a complaint against my last therapist and my experience of intrafamily trauma. It’s like writing on sand. The facts get effaced by the tide.
October 25, 2019

From time to time I have conflicts with my therapist. I think she sees my analytic knowledge as a threat. She will say, “I’m the analyst” as if to emphasize her authority. The following paper calls into question my therapist’s attitude toward me.

On Thursday October 24, 2019 my therapist said to me, “I’m not afraid of you.” I think she is threatened by me. We had been talking about the fact that I had sent my book Psychotherapy Reflections to a supervising-training analyst at the Washington-Baltimore Psychoanalytic Center, Sandra Hershberg, M.D. Dr. Hershberg is a graduate of Yale Medical School. When I told my therapist about my shipping the book to Dr. Hershberg, my therapist got noticeably agitated. I said, “Do you know Dr. Hershberg?” My therapist froze in her seat and she wouldn’t answer my question. In the past when I told my therapist I had sent my book to Dr. Susan Lazar and Dr. Robert Winer, my therapist acknowledged she knew these people. With Dr. Hershberg I got a noticeably different reaction. “I’m not afraid of you,” indeed!

The paper attempts to explore the patient-analyst contribution to the analytic process – focusing mainly on the contribution of the analysand – and how their mutual influence might affect the outcome, sometimes beyond the analyst’s capabilities. This is approached through exploration of the co-creation of an intersubjective analytic field by the analytic dyad, in which the analytic phenomena occur, somehow in both participants, but in an asymmetrical way. Their co-creation of the analytic third in this space includes conflictual as well as healthy elements of themselves. The analyst’s professional self and the analysand’s healthy ego parts form an unconscious alliance directed towards a common cause, the progress of analysis, which unavoidably affects both. Clinical material and vignettes from three cases are presented. In these, becomes apparent that the patient can temporarily take over the analytic situation, permitting continuation of the analytic progress. It is argued that, through the above process, a patient can often help and support the analytic process, surpassing the weaknesses and defects that their analyst might have.

October 9, 2019

Got into an angry argument with my therapist. I wasn’t at all nasty; I was just talking a mile a minute about all the technical problems in her work. “You’ve shown you can’t work with free association. You can’t analyze the resistance. And you have no
idea how to work with transference. You totally ignore issues of extratransferential conflict.” Yada, yada, yada. I was fed up with her looking for relationship issues with everything. It’s maddening to me. Absolutely maddening. I had the feeling she was struck dumb by what I said.

So you know what she said to me? And she repeated this several times. “You’re mean to me. You have a mean streak. You were mean to me.” What am I dealing with here? “You’re mean to me?” Is she ten years old?

Reminds me of an anecdote my sister told me when she was a student teacher in college. She was teaching a class of grade schoolers and she mentioned George Meany, the union leader. She said the kids burst out into laughter about somebody named Meany. They couldn’t get over it. That’s what I thought of.

October 6, 2019

My therapist sometimes refers to my statements as “expelling.” “You are expelling,” she says. She gets this idea from Bion, who talked about “expelling” in psychotically-disposed patients. My therapist has never explained to me how “expelling” even applies to persons with high level ego functioning, let us call them, “neurotically-disposed” patients.

Here’s a passage about Bion’s ideas:

“Should such a fundamental failure occur, the compulsion to avoid facing the pain of physical and emotional suffering can, Bion suggests, precipitate critically damaging consequences. As he puts it in his paper on the Differentiation of the Psychotic from Non-psychotic Personalities, the psychotic engages in the “minute fragmentation of the personality, particularly of the apparatus of awareness of reality” (Bion, 1957, p. 266). In other words, the very organs of emotional perception with which the experience would otherwise be registered may, in cases of extreme adversity, find themselves obliterated and eradicated. Moreover, such a wholesale attempt at neutralising pain can result in these fragments of the personality being expelled into external objects, where they become installed, often as a persecutory force (Bion, 1957, pp. 266–267). In Bion’s (1957, pp. 268–270) terminology, such patients may consequently feel themselves “to be surrounded by bizarre objects” that carry a disturbingly “menacing presence.”
By way of a clinical example of the bizarreness inherent in this psychic self-destruction, Bion, in his work *Cogitations*, recounts a patient who, “when unable to find the selected fact,” externalises the terrifying experience through the enunciation “blood everywhere” (Pistiner De Cortiñas, 2011, p. 143). Bion’s interpretive intervention in this instance was to convey that the patient had attacked their faculty for common sense which they thus saw spread everywhere as blood (Pistiner De Cortiñas, 2011, p. 143). What he was able to achieve with this insight and interpretation was the stemming of the tide by binding the spread fragments and formalising them into a scene (Pistiner De Cortiñas, 2011, p. 143). Cast in the language already prescribed, Bion lends his faculties and ‘dreams’ the “murder of common sense” (Pistiner De Cortiñas, 2011, p. 144) on behalf of his patient, thereby expressing his alpha-functioning and endowing the patient’s experience with significance and meaning (Bell, 2011, p. 94).

When working with patients of a psychotic disposition, Bion emphasises the importance that the analyst is able to provide such auxiliary support by lending their faculties and ‘dreaming’ the session on behalf of the patient. In this respect – and contrary to the view held by both Freud and Immanual Kant for whom “the madman” was regarded as a “waking dreamer” (Stevens and Price, 1996, p. 229) – Bion saw the madman as requiring a waking dreamer in order to ‘dream’ the thoughts he can’t. Furthermore, it is precisely this ‘dreaming’ (explored already as the capacity to consolidate alpha-elements), that provides the psychotic patient with invaluable containing tools for mental growth (Pistiner De Cortiñas, 2011, p. 140). In favourable circumstances, thoughts that previously lacked “a thinker” (De Masi, 2006, p. 51) may, within the carefully contained analytic situation, come to be circumscribed, symbolised and returned by the analyst to the agency from which they came.”

I fail to see how any of this applies to a person with higher-level character pathology who has a capacity for rational thought and symbolization. I have the sense something really strange and crazy is going on in my therapy. It’s as if my therapist’s grandiosity compels her to see herself as Bion or a Bionian (does she really understand Bion, to begin with?) – so that she needs me to be “psychotic” so I can participate in her enactment. That is such a disturbing thought. That is, she needs to label (or mislabel) my psychological processes in a way that will allow her to be Bionian. This is not what I signed up for.
My therapy session on September 26, 2019 featured the following narrative:

[PATIENT:] I spend a frightening amount of time in a semi-psychotic haze, sitting on a park bench listening to music. I just watch people pass by. I watch the world go by as the world moves on. It reminds me of Freud’s analogy for free association. He talked about a person on a moving train, describing everything he sees in the terrain to a companion. I guess I’m talking about therapy when I talk about sitting on the park bench. I’m talking about the frightening amount of time I have spent in a chair in a therapist’s office over the past 27 years. It never goes anywhere.

I think about how my life is so empty but I have this constant swirl of thoughts in my mind. I told you how I feel I have a civil war in my head. That’s constantly going on. But I am not a part of the real world. I am detached from the world. I think about how in my adult life I have recreated the world of the infant in his crib. So his mother has gone off and the infant is alone in his bedroom. But he has this imagination. And he imagines the world of experience, but he is at the same time detached from real experience. And he has a flood if imaginings, of thoughts both satisfying and distressing. But it’s all in his imagination. I feel like that in life. I have this inner movie theater in my mind. I spend my life inside that movie theater and the world goes by outside. But I am in the theater, engrossed in the movie. And in the movie there is a procession of characters, and some of them I like and some of them I don’t like. It reminds me of that dream I had. I told you about that experience I had back in May 1980. I was living in Spokane, Washington. And I went to the movie theater, and there was a volcanic eruption outside, but I had no idea what was happening outside in the real world. I was inside the movie theater, engrossed in the movie. My life is like that. I am in my private inner movie theater, while life passes by outside and I am oblivious to that world outside.

Psychoanalytic thoughts about Vincent Van Gogh suggest a possible interpretation of the therapy narrative. Is it possible that the narrative is an expression of the struggles of the artist: a split between my creative self (as symbolized by the “inner movie theater”—the private world where the reality sense is held in temporary abeyance until it is reinstated) and my ordinary world of social stereotype (the world outside the “movie theater”)? Does the narrative express a split in my sense of identity? See,
Marshall Alcorn has addressed these creativity issues as they relate to the creative writer:

With regard to my therapist’s interpretation that the therapy text perhaps concerned sibling jealousy, note how my therapist is consistently mired in the world of external object relationships and never seems to address my internal struggles. Again, how is my therapist’s work psychoanalytical?

**September 27, 2019**

The work of Sidney Blatt and his colleagues outlines two empirically-supported types of depression, distinguished not on the basis of manifest symptoms but rather on the individual’s unconscious conflicts, defenses and fundamental character structure. Blatt calls these ‘introjective’ depression and ‘anaclitic’ depression, defining introjective depression as follows:

Introjective (self-critical) depression is characterized by a marked vulnerability to disruptions of an effective and positive sense of self and is expressed in feelings of worthlessness, guilt, failure and a sense of loss of autonomy/control. In this type of depression concerns are primarily about disruptions in self-definition and self-esteem leading to feelings of guilt, emptiness, self-criticism and a sense of lack in both autonomy and self-worth. These individuals have a powerful sense of perfectionism, but are vulnerable to criticism both from others and from themselves. Research suggests that such individuals may have histories of parental rejection and **excessive authoritarian control early in life** (Soenens et al., in press). They may often be ambitious and very successful individuals who are plagued by intense self-doubt and criticism, and this group are at considerable risk for serious suicide attempts (Blatt 1995). Previous studies of adult patients suggest that those with this type of depression are less responsive to short-term psychotherapy of whatever modality, but
did show some response to longer-term, intensive psychodynamic psychotherapy (Blatt, 1998).

I seem to have problems with what I perceive as authoritarian control in psychotherapy. I perceive my therapist as controlling and bossy. When I tell her this, she replies, “I feel bossed around by you. You have a need for control.” Where is there any consideration of the transference in my therapist’s observations? Isn’t she, rather, focusing on my manifest symptoms? In fact I am a bossy person. But focusing on my bossiness ignores my unconscious struggles. How does she get at the issue that in early life I struggled with “excessive authoritarian control?” When I talk about my negative feelings about her she sees that as an attack on her, rather than an expression of the revival of feelings I had about my parents in childhood. I am mystified by her saying that her work is psychoanalytical.

An important theme in my book, The Emerald Archive is the individual’s struggles with authoritarian figures, whether it be in municipal bureaucracy or in political dictatorships. The character Oscar Berg, a librarian, struggles with the bureaucracy of the workplace. The character Zelenyi, a free-thinking intellectual, struggles with a political dictatorship.

How is my therapist focusing on my “unconscious conflicts, defenses and fundamental character structure?” I have no idea.

Psychologically Controlling Parenting

Psychological control is characteristic of parents who pressure their children to think, feel, and behave in ways they themselves dictate. Specifically, psychologically controlling parents would intrude upon the child’s psychological world through the use of manipulative and insidious tactics, including guilt induction, invalidation of the child’s perspective, and love withdrawal. As such, psychological control is supposed to have a detrimental impact on children’s self-processes. Consistent with this reasoning, psychological control was found to relate more strongly to internalizing than to externalizing problems, and this relation was obtained even after controlling for the effects of other parenting dimensions, such as responsiveness and behavioral control. Until recently, however, little was known about the psychological dynamics explaining the relation between psychological control and internalizing problems. Recently, perfectionism has been proposed as an intervening variable: Children of psychologically controlling parents would develop a
more perfectionist attitude, which, in turn, would render them vulnerable to internalizing problems [introjective depression].

I note the importance the authors attach to “invalidation of the child’s perspective.” That’s what my therapist does as a matter of routine. When she does this isn’t she reinforcing my pathology? As I said above, I perceive my therapist as controlling and bossy. When I tell her this, she replies, “I feel bossed around by you. You have a need for control.” How does she get at the issue that in early life I struggled with “excessive authoritarian control?” When I talk about my negative feelings about her she sees that as an attack on her, rather than an expression of my subjective perspective. Her response is fundamentally: “When you say I am bossy, you are factually incorrect and you need to disabuse yourself of this distortion of reality.” That’s exactly what controlling parents say to their children. How is that appropriate therapy for me? Isn’t my therapist perpetuating rather than ameliorating my problems?

September 26, 2019

Relaxed session. My therapist said very little. One intervention was worthy of note.

[PATIENT:] September 17th was my sister’s birthday. I sent her a box of strawberries covered in chocolate.

. . . [then, later:]

[PATIENT:] I spend a frightening amount of time in a semi-psychotic haze, sitting on a park bench listening to music. I just watch people pass by. I watch the world go by as the world moves on. It reminds me of Freud’s analogy for free association. He talked about a person on a moving train, describing everything he sees in the terrain to a companion. I guess I’m talking about therapy when I talk about sitting on the park bench. I’m talking about the frightening amount of time I have spent in a chair in a therapist’s office over the past 27 years. It never goes anywhere.

I think about how my life is so empty but I have this constant swirl of thoughts in my mind. I told you how I feel I have a civil war in my head. That’s constantly going on. But I am not a part of the real world. I am detached from the world. I think about how in my adult life I have recreated the world of the infant in his crib. So his mother has gone off and the infant is alone in his bedroom. But he has this imagination. And he imagines the world of experience, but he is at the same time
detached from real experience. And he has a flood of imaginings, of thoughts both satisfying and distressing. But it’s all in his imagination. I feel like that in life. I have this inner movie theater in my mind. I spend my life inside that movie theater and the world goes by outside. But I am in the theater, engrossed in the movie. And in the movie there is a procession of characters, and some of them I like and some of them I don’t like.

It reminds me of that dream I had. I told you about that experience I had back in May 1980. I was living in Spokane, Washington. And I went to the movie theater, and there was a volcanic eruption outside, but I had no idea what was happening outside in the real world. I was inside the movie theater, engrossed in the movie. My life is like that. I am in my private inner movie theater, while life passes by outside and I am oblivious to that world outside.

[THERAPIST:] I had an association. I don’t know if it will resonate with you. I thought about Kine and Ahbel. (Kine and Ahbel?) The Biblical tale of Kine and Ahbel. (Ah, Cain and Abel). You mentioned Spokane, and I thought of Cain. And of course it was a tale of sibling jealousy. You mentioned earlier that you had purchased a gift for your sister, strawberries covered in chocolate. And I related that to Spo-kane and Cain.

[At this point she totally lost me. I had no idea at all what she was talking about and I just fazed out . . . My mind went blank.]

Tell me this is a valid analytic intervention. Tell me the therapist’s intervention made any sense at all. Did that intervention go to the core of what I was talking about: detachment, alienation, the sense of life passing me by, the sense that therapy is useless, my vivid inner world, etc., the lack of a satisfying relationship with my mother and the creation of a compensatory fantasy life, etc. Cain and Abel? The gift of strawberries? Sibling jealousy? Where does she come up with this crap? She gives the impression of an inexperienced analyst who wants to make analytic interventions, but doesn’t have the slightest clue how to do that. She gives the impression that she cannot work with free association.

She gave the impression that somebody talked to her. “You need to integrate the various things that a patient talks about. Look for latent connections between a patient’s thoughts. The patient is telling a cohesive story with elements that have
only a latent connection.” So she is intent on implementing that advice. So what does she do? She looks at the element “strawberries” and the element “Spo-kane” and she then proceeds to confabulate an intervention that is totally nonsensical. But in her mind she thinks: “I am doing what the knowledgeable people instructed me to do.”

September 24, 2019

Parallels between Therapy Relationship and Workplace Relationships

Did my therapist admit today that she has problems in working with me because, unlike other patients, I am not subservient, I am knowledgeable about psychoanalysis, I have a positive attitude, and that I am a person of integrity?

Is it possible that she implicitly acknowledged that these traits in me pose a problem for her.

At my therapy session today my therapist tried to draw a parallel between my difficulties with her and my difficulties with my coworkers at my last place of employment. The fact is that at my last place of employment I was a target of workplace mobbing:

It is recognized that the following traits in a target of mobbing will cause him to be a target of mobbing. “Those targeted are often people who threaten the organizational stasis; and, the most common characteristics identified as reasons for being targeted are refusing to be subservient (58%), superior competence and skill (56%), positive attitude and being liked (49%), and honesty.”

Additional issues also raise questions about my therapist’s relationship with me.

Is it that my therapist wants to control me? Is it possible that she finds me threatening? My intelligence threatens her? My creativity threatens her? My independent personality threatens her? My integrity threatens her? “Bullying and mobbing silence and marginalize targets as perpetrators seek to prevent targets and witnesses from engaging fully in their work, thereby denying them both supportive relationships and their individual identities. The bully decides to target an individual he or she finds threatening. This often involves targeting the “best employees– those who are highly-skilled, intelligent, creative, ethical able to work well with others, and independent (who refuse to be subservient or controlled by others).”
Yes, exactly what did my therapist admit today when she drew a parallel between my problems with her and my problems in the workplace?

September 24, 2019

At my therapy session today I talked about how I felt my therapist’s work was not analytical, but rather supportive counseling. “I have reasons for thinking your work is supportive and not analytical. First, you seem unable to work with free association. You allow some free association, but I have the feeling you can’t work with it. That’s not analytical. Second, you deny my subjectivity. I talk about my impression of you and you don’t allow it.” Ironically, at this moment my therapist cut me off and would not allow me to continue. She offered her thoughts, and I replied, “You cut me off as I was speaking.” She acknowledged that she cut me off, and she said, “I didn’t want you to think you were right.”

Several sessions ago I told my therapist I had decided to cut back on my sessions from twice per week to once per week. I then launched into a chain of associations. My therapist became agitated, and she cut me off. “First, you tell me you only want to come here once a week, you’re done with me, then you get lost in the woods.”

So there are two recent instances where the therapist could not tolerate the act of patient listening. Were these two instances related? In the first instance I was “attacking” her abilities (a narcissistic injury for her). In the second case she felt that I had lost contact with her.

I wonder if my therapist has unacknowledged attachment anxieties that get expressed in her need to be always in contact with me and her needing me to feed her narcissistic integrity. Does she have a struggle about (1) maintaining contact with a (2) nurturing mother? I don’t know. All I know is that she can’t tolerate any criticism, and whatever I talk about, she needs to see my comments as being related to her in some way. For her, nothing can be extra-transferential. Do these two things go together?

September 24, 2019

Therapist’s Role
Therapists may arrive at an impasse when they no longer have the necessary skills or knowledge to treat a client’s particular concern, when a therapeutic modality they are using is not working for the client, or when the client refuses to acknowledge or discuss a particular issue.

Critics within the field of mental health frequently point out that therapists have a tendency to pathologize therapeutic impasses and label them as “bad.” Therapists may blame the client for the impasse and see the impasse as a result of the client’s mental health condition. For example, a therapist might believe that a client who is angry at her therapist is angry because of depression, not because of something the therapist has actually done. It is important for therapists to explore therapeutic impasses as objectively as possible. In many instances, therapists will consult with a supervisor or more experienced clinician to resolve the therapeutic impasse. There are also many articles, books, and trainings that explain strategies that therapists can use to move through or past a therapeutic impasse.

Spent the whole session talking about how I was uncomfortable with my therapist. Every time I said, “You said . . .” she replied, “No, you said that.” So I have no memory.

Every time I said “I feel that you do such and such . . .” she said, “No, you do that.” So I can’t offer her my subjective impression of her. I complained about the fact that she won’t accept my subjective impression of her and she replied: “I don’t want you to think you’re right.” She doesn’t seem willing to allow me to discuss my uncomfortable feelings. Her response is always more or less: “You are wrong. You have no reason to have these feelings. The fact you have these feelings relates to something disturbed in you.” Isn’t it possible we are just not a good fit? Why can’t she admit that?

Reminded me of dealing with a ten year old. “I’m rubber, you’re glue. What you say bounces off me and sticks to you.” Is that a useful or appropriate way to consistently respond to a patient’s negative thoughts about a therapist? She returned to the old saw. “You destroy knowledge. You destroy links.” I said to her, “You destroy knowledge” and she replied, “No, you do that.” I can’t help but believe that she’s not contributing these unproductive sessions.

If a therapist has no analytical skills, she will not be able to analyze the impasse. She will simply blame the patient. That seems clear to me.
Then the end of the session was strange. I said, “I have decided to see you once a week instead of twice a week. I don’t think this is useful for me.” She said, “No. You are going to continue to see me twice a week. I want to understand better the meaning of this.” This has been going on for seven months. She has yet to figure out the meaning of anything. Have you ever heard of a professional who coerces a client to continue professional services? So I gave in. I feel powerless with her.

This is crazy. Tell me this is useful for me.

September 21, 2019

A term from modern psychoanalysis is “follow the contact.” If a patient is here and talking to me and they’re not contacting me, I let them talk. I don’t want to interfere. Every time I say something it alters their thinking process, so I’m very careful about what I say and when I say it. Some patients need a lot of feedback. I give them the feedback. I don’t believe in overly frustrating the patient. Some patients want to just talk, but if they contact me I respond.

Even if they don’t contact me, after a certain amount of time I may contact them just to make sure everything is okay. The other thing you watch is the stimulation level. If somebody is getting overstimulated by what they’re talking about, I may ask what’s called an “object-oriented” question: Something outside of the ego, “Hey, what did you have for breakfast?” It takes them away from the trauma that may be overwhelming them at the moment, sort of pull them back.

– Rafael Sharón

I sometimes complain to my therapist that she talks too much. Her response: “You don’t want me to have my own mind. You don’t want me to have my own thoughts.”

Isn’t it possible that my therapist’s observations about me are simply an artifact of the fact that she will not tailor her technique to my needs? Isn’t it possible that my therapist is simply oblivious to my needs?

The fact is I am one of those patients who doesn’t need a lot of feedback. Some patients need a lot of feedback, a lot of interaction with the therapist. And if the truth be told some psychoanalysts tailor their technique to the needs of the patient. These psychoanalysts get a feel for what the patient needs: a lot of feedback or little feedback. If a patient needs little feedback, the analyst will respect that and offer few
interventions. So, another way of putting it is that my therapist refuses to respect my needs — not that I don’t allow her to have her own mind or her own thoughts.

**September 20, 2019**

**A Therapist’s Naïve Notions about Transference**

My therapist thinks she can limit her work primarily to issues *directly related* to my relationship with her. In response to many of the things I talk about she will immediately and simplistically — and without any reflection — interpret as symbolic of my relationship with her. We might think of transference interpretation as the preeminently necessary hub of the wheel of analysis. But without the spokes, that hub has no value. The spokes of the transference include free association, fantasy and other unconscious antecedents of the transference, as well as childhood relationships and the patient’s present life. My therapist’s transference interpretations are almost uniformly “orphan interpretations.” She will conjecture about the nature of my relationship with her but her interpretations do not grow out of my associations nor does she extend her transference interpretations to my unconscious mental life and relationships, both now and in the past. My therapist’s transference interpretations are the equivalent of the hub of a wheel without the spokes and the wheel. My therapist’s use of what she terms “transference interpretation” raises a substantial question about whether her work is analytic at all or whether it is a form of supportive counseling.

In mid-June I spoke of how I loved June and how the summer solstice was a special time for me. I always experienced a euphoria around the solstice. Instead of listening to my associations to see what that was about, she immediately said: “You are concerned about the issue of time here in our work. You worry that you only get an hour here with me, and you would like more time with me.” I said, “Actually, what I think about during mid-June is the feeling of time standing still. It reminds me of the ‘Augenblick’ in Faust, the Faustian moment, how Faust wanted the sublime moment to last forever. It relates to feelings of euphoria.” Is there a relationship between the desire to make a moment last forever and the idea of “From Here to Eternity,” which I wrote about in one of my dream write-ups?

What were the limitations of the therapist’s interpretation?

1. **My therapist lacks a sophisticated appreciation of the therapist’s contribution to the two-person therapy relationship. She treats therapy as if it were a social conversation.**
My therapist fails to reflect on the timing of her transference interpretations. It is clear that if an idea springs to mind, she will immediately make an intervention. An experienced analyst is well aware that analytic dialogue is not a social conversation where the parties speak up at will. Analytic interpretations need to be properly timed. The timing of a transference interpretation is recognized to be as important as the content of the interpretation. My therapist has no sense of when it is appropriate to speak – and when it is inappropriate to speak. “[Glen] Gabbard defines long-term psychodynamic psychotherapy as 'a therapy that involves careful attention to the therapist-patient interaction, with thoughtfully timed interpretations of transference and resistance embedded in a sophisticated appreciation of the therapist's contribution to the two-person field (emphasis added).” Waska, R. The Concept of the Analytic Contact: The Kleinian Approach to Reaching the Hard to Reach Patient.

2. My therapist failed to listen for associations, which would have given a context to my thoughts about my feelings of euphoria. She seems unconcerned with my past and focuses almost exclusively on my feelings about her in the present moment.

In classic analysis there is a paramount emphasis on both transference AND free association. Free association clarifies the transference; input from free association makes the transference specific and confers nuance on the generalized feelings the patient may openly express about his therapist. There cannot be an adequate analysis of the transference without the input of free association. One cannot simply and immediately reduce every patient utterance to a symbolic expression of the patient’s feelings about the therapist. Even in transference interpretation you need to look at context in the patient’s associations to get a feeling for the precise nature of the transference feelings. But more, insights about the transference then need to be related to extra-transferential concerns, namely, the patient’s childhood, his fantasies, his current relationships, etc. At one session, I opened by saying: “I noticed that you re-arranged the items on your table. You moved the sea shell.” Without my saying more, the therapist replied: “You are having thoughts about your vacation. You are having anxiety about missing sessions because of your vacation.” (Also, note how she continually speaks with certainty. “This is the way it is. There is no other interpretation.”). What was problematic in the therapist’s intervention? The therapist’s intervention was made without input from my associations and my purported anxiety about my therapy situation was not extended to any
extratransferential concerns, namely, my childhood, my fantasies, or other interpersonal relationships.

I note also that my therapist shows a chronic problem with premature interventions and premature closure of my associations. There are analysts who tailor their feedback to the needs of the patient. Rafael Sharón, a certified psychoanalyst, for example, has said: "If a patient is here and talking to me and they’re not contacting me, I let them talk. I don’t want to interfere. *Every time I say something it alters their thinking process, so I’m very careful about what I say and when I say it.* Some patients need a lot of feedback. I give them the feedback." When I state my concerns to my therapist that her interventions interfere with my work, she responds defensively: "You don’t want me to have a mind. You don't want me to have my own thoughts." Again, even this is an "orphan" transference interpretation that has no stated relationship to my total personality or my interpersonal relationships, both now or in the past.

In fact, in my associations about these opening statements, which arose after the session, I thought about my anxieties in terms of Oedipal issues: of “missing the train” to Atlantic City (i.e., career success) and other issues.

I note parenthetically that Melanie Klein had an interesting observation about a patient noticing details in the analyst’s office: “Both in child and adult analyses it is a sign of progress and of the strengthening of the transference when the patient begins to see more details, previously unnoticed, in the consulting-room and in the analyst’s appearance. The analyst is often able to analyze the emotional reasons why these particular objects had escaped the patient’s attention. Such incapacity to see at times even quite large and obvious things illustrates the inhibition of perception for unconscious reasons.” Klein, M. “Narrative of a Child Analysis.”

Harold P. Blum, M.D., a supervising and training analyst, writes: “The analytic process reflects the past, repeats the past, and reviews a past that is given new meaning and definition in the present; the transference itself becomes a major vehicle for reconstructing the past [with the aid of the patient’s associations]. The task of analysis, Freud (1937) stated, is to reconstruct the patient’s childhood from its traces, and in analysis we reconstruct a past no longer directly accessible in the immediate present and that never existed in the way it is reconstructed in analysis.

*We use the technique of extra transference reconstruction [i.e., relating to conflicts and relationships beyond the relationship with the therapist] to*
understand the sources and determinants of the transference, to aid in the resolution of the transference, just as we use the transference itself as our main guide to the patient's childhood conflicts and pathogenic patterns. Transference and extratransference interpretation can be complementary and synergistic. In a broad sense, all interpretation involves transference since there is a transference dimension to all analytic process and all analytic data. Without transference attachment, there could be no analytic alliance and acceptance of interpretation.”

3. My therapist failed to look at precisely how my euphoric feelings were a revival of childhood or infantile feelings of euphoria.

Klein observes: “Whereas I believe that there should be no session without any transference interpretation, my experience has shown me that it is not always at the beginning of the interpretation that the transference should be gone into.

When the patient is deeply engrossed in his relation with his father or mother, brother or sister, with his experiences in the past or even in the present, it is necessary to give him every opportunity to enlarge on these subjects. The reference to the analyst then has to come later. On other occasions the analyst might feel that, whatever the patient is speaking about, the whole emotional emphasis lies on his relation to the analyst. In this case, the interpretation would first refer to the transference. Needless to say, a transference interpretation always means referring back the emotions experienced towards the analyst to earlier objects. Otherwise it will not fulfill its purpose sufficiently. This technique of transference interpretation was discovered by Freud in the early days of psycho-analysis and retains its full significance.”

4. My therapist failed to think about how my feelings of euphoria about the summer solstice concerned extratransferential fantasy or other situations outside the therapy relationship. For example, what was the relationship between my feelings of euphoria and my manic obsession with Dr. P.? Are there deep connections between my idealization of and twinship fantasies about Dr. P.; my mid-June euphoria; and the effort I invest in self-analysis that can be traced back to my internalized good object? Klein writes: “The longing to understand oneself is also bound up with the need to be understood by the internalized good object. One expression of this longing is the universal phantasy of having a twin . . . . This twin figure [] represents those un-understood and split off parts which the individual is longing to regain, in the hope of achieving wholeness and complete understanding; they are sometimes felt to be the ideal parts. At other times the twin also represents an entirely reliable, in fact, idealized internal object.” Klein, M., “On the Sense of Loneliness.”
In this respect, Blum emphasized that analytic understanding of the patient should encompass the overlapping of transference and extratransference spheres, fantasy and reality, past and present.

Blum writes: “The manifestations of certain conflicts may appear in transference but may evade analytic understanding based only on transference. Conversely, certain conflicts may be sharply reactivated, as in the case of separation anxiety and depression, during termination of analysis or following a divorce or a death in the family. Relatives may resist or assist the patient’s analysis, and familial change may provide secondary gain or mature gratification. Each patient reacts to the significant real events of life in his own particular fashion, based on his total personality, and some ego-syntonic character patterns may remain distant from transference conflict and analysis.” Blum, H., “The position and value of extratransference interpretation.”

My chronic, manic obsession with Dr. P. is obviously psychologically important and has unconscious antecedents. But you won’t find representations of that obsession if you only look at my feelings about my therapist, which are largely negative. What my therapist does is totally ignore my feelings about Dr. P. because she sees that it falls outside the transference, so in her heuristic my feelings about Dr. P. are meaningless and not worthy of interpretation.

5-- My therapist failed to think about the negative transference aspects of my comments about the solstice. In some sense in talking about my mid-June euphoria wasn’t I saying: “These euphoric feelings in mid-June are what I long for in a therapy relationship. At times I had these feelings with Dr. Palombo, but I never have these feelings here, and I long for them. I long for that kind of relationship with a therapist. A feeling of euphoria in a therapeutic relationship.” Wasn’t I saying, perhaps: “My feelings about mid-June are the opposite of what I feel here. It’s as if when I am here I feel I am in the dead of winter. I feel cold and lifeless here.” The French writer Albert Camus wrote: “In the depth of winter, I finally learned that within me there lay an invincible summer.” Are my euphoric feelings about the summer solstice a manic defense against psychic pain, loss and mourning?

Klein observed: “Attempts to bring about a positive transference by neglecting the analysis of the negative one cannot, I believe, achieve lasting results.” Klein, M. “Narrative of a Child Analysis.” My therapist treats my expressions of negative transference as attacks on her. She seems psychologically incapable of dealing with my negative thoughts and feelings about her. The therapist’s internal prohibitions preclude any thoughtful consideration of my negative transference. My therapist
seems oblivious to the fact that without an antecedent analysis of my negative transference, a positive transference might never develop.

*September 20, 2019*

The following is an actual conversation between a therapist and abusive patient.

My therapist complains that I “pick fights” with her because I complain that she fails “to listen to me with evenly hovering attention,” she doesn’t allow me to express myself, and she doesn’t permit free association.

It’s as if my therapist erases the difference between, one the one hand, my thoughtful concerns, and, on the other, a patient calling his therapist an “asshole.”

That’s basically what she’s doing. As I wrote before, “A fellow analyst reading her process notes might very well form the opinion that ‘picking fights’ refers to my heated and personally abusive attacks, when in fact all that I expressed was my discomfort with her technique, using appropriately descriptive language. If I say, ‘I think you talk too much’ — her interpretation is ‘You are picking a fight with me.’ Once again, these distortions of objective reality are what we find in persecutory states (and political dictatorships—in a political dictatorship, if a disgruntled citizen writes a reasonable letter of complaint to a government official he might well be charged with sedition).”

I find that offensive. And I find it psychologically manipulative that she seems to try to turn herself into a victim of my “aggression” simply because I voice my concerns about her work in a respectful and thoughtful manner. *What patients complain about the lack of “evenly hovering attention?”*

The bottom line is she doesn’t like being criticized. That’s all. And a lot of that has to do with her sense that she’s an outstanding “psychoanalyst.” I don’t know how many times she has worked in the statement, “I am a psychoanalyst.” Can you imagine David Callet repeatedly telling a client, “I am a lawyer.” *What is up with that?*

This issue reminds me so much of the interaction between President Trump and CNN’s Jim Acosta last November. Acosta asked Trump a question he didn’t like, so
Trump attacks him: ”You are a rude, terrible person.” Notice how Trump deflected attention away from the content of Acosta’s question to a distorted depiction of Acosta’s behavior. That’s exactly what I said about my therapist. She transforms my thoughts into behaviors — because she doesn’t like the content of my thoughts.

She may be a narcissist, but I don’t know.

September 10, 2019

I opened the session by announcing that I planned to go forward with my previously-stated intention to cut back my sessions, from two sessions per week to one session per week. I then embarked on a train of discursive thoughts about fleeing from therapy, comparing myself to an army deserter in wartime, I talked about how my whole life seemed like a desertion; I then focused on my “someday fantasy,” the idea that someday someone would arrive on the scene who would be my protector, my salvation—”like Wager’s opera, Lohengrin, an idealized figure who would someday appear and change my life circumstances.”

At this moment the therapist cut me off abruptly. She didn’t want to hear anymore. She said, irritated. “You come in here, you tell me you want to see me once a week, then you’re done with me — and then you get lost in the woods.” She treated my opening comments as if they were meaningless. Later in the session, I pointed out how my opening comments fit a recurring pattern in my thinking, and appeared to conform to an internal schema, namely, my feeling that I was engulfed by my mother, I wanted to flee her, and unite with a distant, but idealized father. Indeed, at an earlier session, I said that while I was seeing Dr. Palombo in 1990 I saw him as my “Lohengrin-protector,” (and had actually purchased a recording of the opera, which I listened to obsessively during the summer of 1990.) My therapist knew at some level that my Lohengrin fantasy was an aspect of my positive transference with Dr. Palombo, and that a subtext of my overt reference to Lohengrin at this session was my transference feelings about Dr. Palombo. I offered the thought that perhaps my reference to a “Lohengrin-protector” had triggered her “envy” (more accurately, jealousy) which compelled her to shut me down in a pique. The therapist responded: “My envy?”

It is well to keep in mind that the so-called “someday fantasy”—that is, my “Lohengrin protector fantasy” is a recognized schizoid fantasy with defined dynamics. An abstract of Salman Akhtar’s paper about the fantasy reads: Fantasies
whose core is constituted by the notions of “someday” and “if only” are ubiquitous in human psyche. In severe character pathology, however, these fantasies have a particularly tenacious, defensive, and ego-depleting quality. The “someday” fantasy idealizes the future and fosters optimism, and the “if only” fantasy idealizes the past and lays the groundwork for nostalgia. The two fantasies originate in the narcissistic disequilibrium consequent upon the early mother-child separation experiences, though the oedipal conflict also contributes to them. Both can be employed as defenses against defective self and object constancy as well as later narcissistic and oedipal traumas. The literature suggests six tasks to be especially important for analytic work with such patients: (1) providing and sustaining a meaningful "holding environment"; (2) employing "affirmative interventions"; (3) helping the patient unmask these fantasies and interpreting their defensive, narcissistic and sadomasochistic aspects; (4) rupturing the patient's excessive hope, analyzing the effects of such rupture, and facilitating the resultant mourning; (5) reconstructing the early scenarios underlying the need for excessive hope; and (6) paying careful attention to countertransference feelings throughout such work. Akhtar, S. "'Someday ...' and 'if only ...' fantasies: pathological optimism and inordinate nostalgia as related forms of idealization."

The therapist occasionally refers to my act of “destroying knowledge.” Note how the therapist herself took my opening comments — rich in analytic meaning — and (to use Dr. Shengold’s exquisitely descriptive term) “reduced them to shit.”

1. **In treating a creative patient with high executive functioning it is inappropriate to stifle the patient’s retreat into fantasy.**

At my therapy session on September 10, 2019, my therapist said that I sometimes “go off into the woods” in my sessions; she seems to mean that I have a tendency to retreat into fantasy that is not grounded in reality, all the while ignoring her presence. Keep in mind that I had a perfect score on the Wisconsin Card Sorting Test, indicating high executive function. For me, loss of contact with reality is an adaptive function mediated by ego strength. When we speak of a “loss of contact with reality” are we not describing the creative process itself? The creative individual loses himself in his work and then returns to himself with a deepened self-awareness. A quote by Henry David Thoreau (Walden) perhaps expresses this idea: “Not till we are lost, in other words not till we have lost the world, do we begin to find ourselves, and realize where we are and the infinite extent of our relations.” Two passages in my book Significant Moments use the idea of
“going off into the woods” as a metaphor for creativity, that is, the artist’s losing himself in fantasy – then returning to the world of objective reality. In both passages from the book, a character “retreats into the wilderness” or “gets lost in the woods” only to return to the real world. This literary idea is a metaphor for the adaptive regression of the artist.

“The creative process involves an essential dialectic between the freedom and ambiguity of fantasy and the control of rational thought, between physical events and semantic meaning, and between infinite variety and oneness. The creative endeavor becomes an attempt to capture some facet of this variety in a manner that brings the onlooker closer towards the essential form that underlies it. In this way, the particular becomes a manifestation of multiplicity. Creative acts are a part of the real world, and at the same time are separate from the real world. Creativity presupposes play with reality, a demiurgic creation of alternative, multilevel worlds of meaning, layer on layer, from archaic roots to the newly created surface. Such multilevel meaning making is a distinctive characteristic of products of art and the psychoanalytic process, and originally, of our mental apparatus. Each new-created meaning level is rooted in, but also partially destroys already established strata of meaning.” Andrzej Werbart, The Art of Freedom: Seven Psychoanalytic Theses on Creativity and Boundaries.”

Frank Barron, a leading creativity researcher, found that creative persons "have strong egos that permit them to regress and to return to normality." Again, the loss of reality in creative persons – their concomitant retreat into fantasy – is an adaptive function and not an indicator of psychopathology.

Does the therapist have an ability to work with creative patients who have high ego strength?

2. In working with a creative patient with high executive functioning it is inappropriate to stifle the patient’s use of free association or to direct him to bring his associations within the purview of the “observing ego.”

In the Interpretation of Dreams, Freud offers an exquisite discussion of the basic technique of analysis – free association. At my session on September 10, 2019 my therapist said to me, “You want me to let you go off into the woods with your ideas. You need to bring your ideas under the control of your observing
ego.” What does Freud say about the role of the “observing ego?” In fact, Freud addresses this issue directly: “In the case of a creative mind [or the patient doing analysis], it seems to me, the intellect has withdrawn its watchers from the gates, and the ideas rush in pell-mell, Freud (quoting Schiller) is saying that for the moment, in the analytic situation, the patient’s ego needs to “withdraw its watcher from the gates” that is, detach the observing ego from the flow of thoughts and feelings. The therapist’s directive is inimical to psychoanalysis and appears to be rooted in supportive psychotherapy. The therapist’s direction would appear to be the antithesis of analysis.
Freud writes:

“There are many people who do not seem to find it easy to adopt the required attitude toward the apparently ‘freely rising’ ideas, and to renounce the criticism which is otherwise applied to them. The ‘undesired ideas’ habitually evoke the most violent resistance, which seeks to prevent them from coming to the surface. But if we may credit our great poet-philosopher Friedrich Schiller, the essential condition of poetical creation includes a very similar attitude. In a certain passage in his correspondence with Korner (for the tracing of which we are indebted to Otto Rank), Schiller replies in the following words to a friend who complains of his lack of creative power: ‘The reason for your complaint lies, it seems to me, in the constraint which your intellect imposes upon your imagination. Here I will make an observation, and illustrate it by an allegory. Apparently it is not good — and indeed it hinders the creative work of the mind — if the intellect examines too closely the ideas already pouring in, as it were, at the gates. Regarded in isolation, an idea may be quite insignificant, and venturesome in the extreme, but it may acquire importance from an idea which follows it; perhaps, in a certain collocation with other ideas, which may seem equally absurd, it may be capable of furnishing a very serviceable link. The intellect cannot judge all these ideas unless it can retain them until it has considered them in connection with these other ideas. In the case of a creative mind, it seems to me, the intellect has withdrawn its watchers from the gates (i.e., the “observing ego”), and the ideas rush in pell-mell, and only then does it review and inspect the multitude. Yon worthy critics, or whatever you may call yourselves, are ashamed or afraid of the momentary and passing madness which is found in all real creators, the longer or shorter duration of which distinguishes the thinking artist from the dreamer. Hence your complaints of unfruitfulness, for you reject too soon and discriminate too severely’ (letter of December 1, 1788).” Freud, S., The Interpretation of Dreams.
There is a striking parallel between this technical rule of psychoanalysis (free association) and the advice about how to become “an original writer in three days,” formulated in 1823 by Ludwig Börne and quoted by Freud a century later: “Take a few sheets of paper for three days on and write down, without fabrication or hypocrisy, everything that comes into your head . . . and when three days have passed you will be quite out of your senses with astonishment at the new and unheard-of thoughts you have had.” Andrzej Werbart, “The Art of Freedom: Seven Psychoanalytic Theses on Creativity and Boundaries,” citing Freud, S. “A note on the prehistory of the technique of analysis” (1920).

3. **It is questionable analytic technique to stifle a patient’s free expression or to demand that the patient heed the presence of the analyst. A patient’s act of ignoring the analyst’s presence is an analyzable issue.**

My therapist complained that I have a tendency to act as if she isn’t even present in the room. My response? Her statements probably tell us more about her limitations as an analyst than anything problematic that I am doing.

The following is an actual analytic narrative. The following patient is not just lost in the woods — he’s totally lost in a forest! Yet the analyst permits the patient to expand his discursive narrative — and offers an accepting intervention. Note the analyst's credentials. Not only is he a top notch analyst but he is, of all things, a follower of Bion! The analyst, Joseph A. Cancelmo, PsyD, FIPA, is former president, training and supervising analyst and facility of the Institute for Psychoanalytic Training and Research (IPTAR), and a Fellow of the International Psychoanalytical Association (IPA). He has published articles on the application of Winnicott’s and Bion’s ideas to clinical process.

**ANALYTIC TEXT:**

Mr. B: I’m late here today, so I’m feeling not here . . . like I spoiled it so what’s the point . . . . I can feel myself on the surface of things, distant but I’m tied into you at the same time . . . . It all feels disjointed . . . the questions keep coming. why am I here . . . who is this for? I’m tied up with you and resisting at the same time. Had a similar feeling with Dee [his wife] this morning . . . . I got her text message she was on her BlackBerry, so I know she’s right there, so it was nice and immediate, right there to me, but it feels like a demand to respond to her . . . I can’t have my own good feeling because hers takes over. She says she liked how I looked while
shaving this morning; she said she was looking forward to the weekend. I feel I can’t be free in the midst of her need for me . . . no way I can do my thing . . . have to respond to her wish to be with me . . . I feel enslaved by her wanting me even though I want her . . . she has to take precedence. I can only have this dialogue in my head, not in reality with Dee . . . can’t risk the exposure. I’m telling you all this right now . . . and it feels like you’re not here . . . like I am talking to myself and hearing about myself . . . presumably you are the audience, so you must be here but you’re not here. I can talk but it seems unreal.

Analyst: You have some sense I exist, as an audience, but you need to leave me out of the equation, so maybe you don’t feel caught up with a sense of pressure and demand you’ll feel noting that I am here listening even though you are late maybe you fear using me here because you will end up feeling used, and tending to me, so the price is feeling unreal.

Mr. B: I can’t navigate this with you . . . with Dee . . . like in the triangle with my mother and father. Can’t have one if I’m aligned with the other . . . it’s the “Vulcan mind meld”; if I’m close and connected, I’m inside their thoughts and needs, they become mine, but then where am I? I feel like that right now . . . F YOU!! [with anger] I don’t want to have to be present . . . it’s painful to take the space for myself and then in the same breath feel doomed to regret it . . . I will end up having to lose something. [tearfully] I had no right to let that out . . . that anger and frustration. You only let me hear back what I’ve been saying. I see that you are alive here and I register for you, I have an impact on you here when I’m not present. But you don’t seem to mind, to begrudge me. I hear you but I see my mother’s angry face, the scowl and then the dead absence, the silence in the house, the icy removal . . . It feels hopeless . . . I know I’m rejecting your help right now when I say that . . . It always comes back to this . . . has it changed? Do I want it to change? I remember your old office . . . saying how hopeless I felt . . . this feels not so bottled up, not so hopeless, but I can’t fully give that to you . . . I imagine you could hold it against me and expect repayment for helping get to a less hopeless place . . . a constant debt to repay so I get caught up in my enslavement again . . . it is something I know, it’s reliable.

4. Conflicts in the Therapy Relationship caused by a Possible Disparity in Ego Strength

The psychologist Donald MacKinnon gathered personality data on architects. The data clustered into three personality types: (I) the artist (creative), (II) neurotic (conflicted; artiste manqué), and (III) the average (adapted). (Architects were chosen because they combine art with science, business, even psychology). His research found significant differences among the three groups.
Group I scored highest, in MacKinnon’s analysis, on aggression, autonomy (independence), psychological complexity and richness, and ego strength (will); their goal was found to be “some inner artistic standard of excellence.”

Group II scored intermediate on independence, close to (I) on richness, and highest on anxiety; their goal was “efficient execution,”

Group III scored highest on abasement, affiliation, and deference (socialization); their goal was to meet the standard of the group.

Problems may arise in the analytic relationship where a “Group III” analyst who emphasizes relatedness treats a “Group I” pathologically introjective patient. There may be a conflict based on the respective levels of ego strength of patient and analyst. The analyst runs the risk of continually finding herself threatened by the Group I patient’s aggression, autonomy, psychological complexity, and ego strength.

It is well to keep in mind that there are similarities between the thought process of creative persons and the primary process thinking of psychotics.

Beginning with Freud, but especially since Kris’ explorations of creative processes, psychoanalytic theorists have described relationships among creativity, primary process, and a particular kind of ego control that permits adaptive use of primary process. The concept “regression in the service of the ego” refers to a momentary and at least partially controlled use of primitive, nonlogical, and drive dominated modes of thinking in the early stages of the creative process. Holt, R., “Creativity and Primary Process: A Study of Adaptive Regression.”

Creative artists, compared with noncreative persons and schizophrenic persons, are better able to move back and forth between mature and primitive thought processes. In his review of the literature on primary process thinking and creativity, Suler concluded: “The loose and at times illogical and fantastical ideation characteristic of formal primary process undoubtedly contributes to innovative thinking. This capacity to master the cognitive complexity imposed by subjective states of drive and affect reflects the more general ability to cope with the complexities in thought inherent in any scientific or artistic creative process. Feist, G.J., “Affect in Artistic and Scientific Creativity.”
I suggest that because of the therapist’s possible lower ego strength compared with mine that my free associations or other clinical material arouses psychotic anxiety in her. It is possible that the therapist, owing to her lower level ego strength, is unable to distinguish the narrative of a psychotic from the narrative of the creative person.

Thus, if I open a session as follows . . .

I feel like I’m fleeing. It’s like I’m in an act of fight. I’m fleeing from you. I’m fleeing from therapy. You know, I feel like a deserter in the army. It’s like there’s a combat situation and I can’t face that face the danger, so I become a deserter. But then I think about how things could be different for me. I have this fantasy of an idealized person who will rescue me. Like Wagner’s opera, Lohengrin.

Lohengrin is an idealized person. I yearn for that person who would be my salvation, my protector. Someday, someone who would change my life. That’s what I yearn for . . .

. . . what the therapist hears me saying may be something along the lines of the following (a verbatim transcript of a schizophrenic patient as reproduced by Albert Rothenberg, M.D., Creativity and Madness):

I’ve never been confused as much as I have been recently. Confusion was nothing to me. It was fun. I loved art, I loved to have my hands in every single thing I could get them in. And when I’m here I don’t have the facilities to dig in the garden and put my feet in the mud and I just can’t stand that . . . feeling. I, I need to be free like most of us do, because I feel like a bird when I’m up in the air for any length. I feel like a bird when I’m skiing, I feel like I could fly if I really tried but I wouldn’t try because – hee, hee – it’s beyond my power. Maybe someday they’ll perfect it so that a person can fly without . . . walking. But they better hurry up! Because there’s too many guys on the road right now.

5. Evidence that the Therapist’s Knowledge of Kleinian Theory is Shallow and Does Not Rise to a Level that Has Any Clinical Value

By a process of free association I thought of the possible connection between the “Someday Fantasy” (that is my “Lohengrin-Protector” Fantasy) and the Kleinian positions. I was struck by the fact that one of my favorite poems (“Worship” by Hermann Hesse) contains themes suggestive of Someday Fantasy as well as depressive anxiety.
Is it any wonder why I love the following poem? Does it relate to the “Someday Fantasy” described by Salman Akhtar? I note the pervasive depressive anxiety in the poem. Hesse talks about a world destroyed and mourned for and the hope that — someday - the bits will be put back together.

In the beginning was the rule of sacred kings
Who hallowed field, grain, plow, who handed down
The law of sacrifices, set the bounds
To mortal men forever hungering
For the Invisible Ones' just ordinance
That holds the sun and moon in perfect balance
And whose forms in their eternal radiance
Feel no suffering, nor know death’s ambiance.

Long ago the sons of the gods, the sacred line,
Passed, and mankind remained alone,
Embroiled in pleasure and pain, cut off from being,
Condemned to change unhallowed, unconfined.

But intimations of the true life never died,
And it is for us, in this time of harm
To keep, in metaphor and symbol and in psalm,
Reminders of that former sacred reverence.

Perhaps someday the darkness will be banned,
Perhaps someday the times will him about,
The sun will once more rule us as our god
And take the sacrifices front our hands.

—Hermann Hesse, Magister Ludi. The Glass Bead Game

Thereupon, I googled “Someday Fantasy” and “depressive position,” and, lo and behold, the search led directly to a book by Salman Akhtar titled: Inner Torrent Living Between Conflict and Fragmentation. Indeed, in that book Dr. Akhtar introduces his discussion of Someday Fantasy with a reference to the Kleinian positions: “Hope in the paranoid-schizoid position is easy, a longing for a magical, omnipotently controlled, easily exchangeable object. Hope in the depressive position requires great courage, a longing for an all-too-human, irreplaceable object, outside of one’s control,” quoting Stephen Mitchell.
When I embarked on associations to the Someday Fantasy (the Lohengrin-protector fantasy), my therapist cut off my discussion as if my thoughts were meaningless and of no analytic significance. What does that say about her ability to be a patient listener, her curiosity, her ability to invest energy into looking for the significant in the seemingly insignificant, and of course the depth of her understanding of Kleinian theory, which she is so fond of referencing.

In short, what is the therapist’s ability “to take trouble?” It has been said that

—highly creative people show the mental energy to invest energy into idea production (note the therapist’s inability to be a patient listener and form theories about my narrative);

—have the gift of finding patterns where others see nothing but a chance collection of objects (the therapist seems to be a sequential thinker rather than a holistic thinker; What is the analytic significance of my pattern of military metaphors from session to session, such as, “I feel like I have a civil war in my head” and “I feel like an army deserter fleeing combat,” see, e.g., Berkower, L.R., “The Military Influence Upon Freud’s Dynamic Psychiatry”);

—have a memory for essential details (the fact that I had earlier told the therapist that my fantasies about Dr. Palombo centered on the literary figure, Lohengrin; her failure to think about that essential detail revealed a gap in her ability to think about transference, namely, “How does the patient’s transference with Dr. Palombo differ from his transference with me—and why does it differ?”);

—a capacity for taking trouble (the therapist seems unable to allow a patient’s narrative to reveal its full potential).

**September 18, 2019**

You are at a consult with your cardiologist. He talks about the five chambers of the heart. — *You never want to have that conversation with anybody who calls himself a cardiologist.*

Early in my therapy, perhaps within the first five sessions, I had the following conversation with my therapist, a psychoanalyst-in-training. My therapist’s statements
exposed problems in her understanding of the fundamental aspects of psychoanalysis as well as her capacity for symbolic thought. — You never want to have this conversation with anybody who calls herself a psychoanalyst.

PATIENT: I’ve been thinking about our work. I have problems with what we’re doing here. I just don’t understand what we’re doing. I mean, I’ll talk about something and you will comment. I’ll talk about something else and you’ll comment. Our sessions seem to go on and on like that. I have the idea that you have no concern for the whole session, the totality of what I talk about. It’s as if you have no sense of context and how one idea alters the meaning of seemingly unrelated ideas I talk about. You know, in analysis, context is very important. Did you ever hear of Freud’s archaeological metaphor? Do you know about that?

ANALYST [angrily]: Of course, I know about Freud’s archaeological metaphor!

PATIENT: Well, my understanding is that a session is like an archaeological dig. So let’s say you’re an archaeologist and you’re digging some ancient site and you come across a cup from thousands of years ago. What is the meaning of that cup? What is the nature of the site? Simply thinking about the cup is meaningless. It’s just a cup. But a cup can mean anything. But if you find cooking and eating utensils and animal bones those additional items give you a sense of the whole and suggest you have unearthed a kitchen perhaps, or someplace that people ate. But the cup didn’t tell you that. It’s all the artifacts taken together that tell you that. But imagine you find the cup along with human bones and jewelry — that tells you something. It could be a burial site. It could be somebody’s grave. But then you find the cup with other items that seem to be of a ritual nature — very valuable items of gold and strange objects that don’t seem to have any practical value — this could be the site of religious rituals, a place that was holy to these ancient people. The cup itself tells you nothing. It’s the . . . [analyst cuts me off abruptly].

ANALYST [notably angry and irritated]: Cup! Cup! Why are you talking about a cup? I never said anything about a cup! Why are your talking about a cup?

*You never want to have that conversation with anybody who calls herself a psychoanalyst. I should have known right then and there.*

*September 18, 2019*
My therapist is unable to tolerate feedback or criticism. The following discusses the need for a therapist to work with the patient’s criticism and not become defensive:

Traditional psychoanalytic technique advises the analyst to respond nondefensively in the face of intense negative transference, i.e., to not take it personally. Shaw’s clinical examples make clear that such recommendations may be unrealistic. Negative transference is personal because it might be provoked by the analyst’s narcissistic investment in his or her therapeutic approach, which is the presumption and conviction that his or her therapeutic approach is inherently helpful (i.e., the analyst’s narcissistic impenetrability). Inevitably, analysts do respond in unconsciously defensive ways when their adequacy as therapists is seriously challenged. It is painful for analysts to tolerate the accusation of a traumatized patient, when that patient feels the treatment is more hurtful than helpful, without responding with at least implicitly defensive self-justification, emotional withdrawal, or subtle counterattack. The analyst might feel that the patient is being sadistic in falsely accusing him or her of malevolence or incompetence when the analyst is doing his or her best to be helpful with an exceedingly difficult patient. Shaw’s clinical examples illustrate how these moments of truth, which could result in serious therapeutic impasse, can be worked through with a combination of therapeutic humility, honest self-disclosure, and verbalization of thoughtful reflections about the analyst–patient relational dynamics.

BOOK REVIEW: TRAUMATIC NARCISSISM: Relational Systems of Subjugation, by Daniel Shaw.

September 18, 2019

I am an honest therapy patient. I talk frankly with my therapist about my feelings. Many patients lie to their therapists about their true feelings:

I am an honest person. Therapists perhaps are not used to patients who have a high level of integrity. That might be my problem for me. I find it interesting that my therapist doesn’t see that. A sleazy therapist would tend not to see that.
September 18, 2019

Pervasive Mendacity in an Analyst-in-Training?

To know and not to know, to be conscious of complete truthfulness while telling carefully constructed lies, to hold simultaneously two opinions which cancelled out, knowing them to be contradictory and believing in both of them, to use logic against logic, to repudiate morality while laying claim to it, . . . to forget whatever it was necessary to forget, then to draw it back into memory again at the moment when it was needed, and then promptly to forget it again: and above all, to apply the same process to the process itself – that was the ultimate subtlety: consciously to induce unconsciousness, and then, once again, to become unconscious of the act of hypnosis you had just performed. Even to understand the word ‘doublethink’ involved the use of doublethink.


1. . . . to hold simultaneously two opinions which cancelled out, knowing them to be contradictory and believing in both of them . . .

At my therapy session on September 17 my therapist and I talked about my letters. I said, “You say that I am attacking you or picking fights with you when I criticize your work. But I think that any supervising analyst would have problems with some of the things you say. For example, when you said, ‘Your thinking is ideographic and not symbolic’ – any supervising analyst would say, ‘You shouldn’t use jargon with a patient.’ I think that perhaps there are probably numerous instances where a supervising analyst would agree with the things that I say about your work. And yet, when I say these things you say I am picking fights with you.”

She responded, “You aren’t in analytic training. I am. You don’t know what a supervising analyst would say.”

Notice how my therapist used “logic against logic.” She first stated an indisputable fact: “I am in psychoanalytical training and you are not.” But then she made a statement that existed simultaneously with an opposite viewpoint that the therapist has used on other occasions. “You have no idea what an expert would say.”
In effect, she was saying “I have expertise in this area. You do not. I know what I am talking about. You don’t.”

But compare the following:

At a previous session I talked about contracting scarlet fever when I was three years old, and my pediatrician attributing the illness to spoiled milk that my mother had allowed me to drink. The therapist said: “Maybe the spoiled milk didn’t cause the scarlet fever. Maybe the doctor was wrong.”

The therapist is not a medical doctor and, presumably, has no expertise in infectious diseases, but she second-guessed the professional judgment of an experienced medical doctor. The therapist, according to her own precept (laymen cannot conjecture about an issue that requires an expert opinion), had no idea whether the doctor was correct or not in his medical judgment.

Compare the following:

I provided the therapist a copy of a criminal complaint I had filed with the FBI that alleged that my primary care doctor committed perjury when he stated in an affidavit that he was afraid of me. Even after reading my criminal complaint, my therapist said, “Your doctor was ‘very afraid’ of you.” The therapist is not a lawyer. I am. According to her own precept (laymen cannot conjecture about an issue that requires an expert opinion) she had no basis to weigh the merits of my legal opinion that the doctor had committed perjury when he said he was afraid of me.

2. . . . to repudiate morality while laying claim to it . . .

At the session on September 17, when I complained that my therapist did not allow me to criticize her work, she replied: “I do accept criticism. I welcome criticism.”

But compare the following:

In the past when I have offered reasonable and thoughtful criticisms in a respectful manner, she alleged that I was “picking fights” with her.
I have criticized her work on numerous occasions. Not once did she acknowledge that I had a valid criticism, and she has resorted to psychoanalytic jargon to invalidate my statements: “You are attacking links,” “You are destroying knowledge,” “your thinking is idiographic and not symbolic,” “You are expelling.”

On one occasion she praised Bion, saying that he permitted his patients to use him as a “container,” thereby affirming that technique was therapeutically valuable. When I seem to use her as a “container,” she will attack me.

On one occasion she affirmed with approval Melanie Klein’s technique of analyzing the patient’s negative transference (and not simply the positive transference). When I exhibit negative transference she will attack me or invalidate my thoughts.

Notice how a therapist with these character flaws will undermine any confidence in her integrity and expertise — and undermine any opportunity to build trust with a patient.

**September 27, 2019**

I had a therapy session today. We talked about my letters. I said, “You say that I am attacking you or picking fights with you when I criticize your work. But I think that any supervising analyst would have problems with some of the things you say. For example, when you said, ‘Your thinking is ideographic and not symbolic’ — any supervising analyst would say, ‘You shouldn’t use jargon with a patient.’ I think that perhaps there are probably numerous instances where a supervising analyst would agree with the things that I say about your work. And yet, when I say these things you say I am picking fights with you.”

Her response was a “weak argument.”

She said, “You aren’t in analytic training. I am. You don’t know what a supervising analyst would say.”

Why is that argument “weak?” First, it is true that I have no first hand experience with analytic training. But all I have to do is go to Google and search the terms “supervising analyst” and “jargon” and I will come up with some material directly pertinent to what a supervising analyst would say about the use of jargon or any number of issues.
See the following paper:
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What does he say about the use of jargon with adolescents?

“Use of jargon will be experienced as intimidating, off-putting and indicative of yet another adult who does not ‘get’ where the adolescent is coming from.”

Here’s an observation from another “hit” on Google:

Robert J. Stoller, M.D. (1924-1991) was the author of eleven books and over 115 psychoanalytic articles. He did pioneering work in the study of gender identity and sexual excitement while teaching at UCLA and the Los Angeles Psychoanalytic Institute. He introduced the distinction between sex and gender to psychoanalysis, a distinction now taken as basic. His early papers on primary femininity are classics in the study of female development. His later investigations of transsexuals, transvestites, and pornography were controversial but remain at the center of psychoanalytic discussions of sexuality. He was widely known as a brilliant clinician and supervisor. His interests were far-ranging and led him repeatedly to challenge what he saw as received wisdom or use of jargon, particularly psychoanalytic jargon. He was an outspoken advocate for bringing fresh and vitalizing perspectives to bear on psychoanalysis by considering relevant findings from other fields.

I am guessing Dr. Stoller would be appalled by one of his supervisees saying to a patient: “Your thinking is idiographic and not symbolic.”

How do you deal with a person like this? I make valid points, but, like any good lawyer who has a weak case, she will come up with plenty of opposing arguments but they will all be crap. It goes on and on like that — if I am lucky. If she has no opposing arguments she falls back on her old standby, “You are picking fights with me.”
My therapist says I pick fights with her. She leaves it at that. She makes no attempt to tap into my subjective experience: how do I experience her–how does my subjective experience of her cause me to “pick fights with her?” My therapist is unable to immerse herself in my subjective world. That’s not analysis. Without an appreciation of the patient’s subjective world there is no analysis. My therapist makes no attempt to look at the unconscious antecedents or the biographical antecedents of my “picking fights” with her. I uncovered a case similar to mine. The analytic patient continually attacked the analyst. The author of the following text shows how the analyst’s response to the patient’s behavior was not appropriate. See, Brandchaft, B., Doctors, S. and Sorter, D., Toward an Emancipatory Psychoanalysis: Brandchaft’s Intersubjective Vision.

Robert Stolorow talks about a patient subjectively experiencing the analyst as thwarting his selfobject needs — and when the patient voices his concerns about this to the analyst, the analyst views the patient’s communication as a malignant attack. That’s an exquisite insight into my therapist’s idea that I pick fights with her or “attack” her.

Why is it that my therapist has no insight at all into this process? Why? Because her work is amateurish, uninformed and shallow. And, yes, I am attacking her. Any analytic supervisor who knows anything would have problems with her as well.
September 13, 2019

I sometimes complain to my therapist that she talks too much. She gives the impression that when she has a thought, she needs to speak it — that is, communicate it to me. That doesn’t seem analytical to me. In analysis, the
occasion for the analyst to speak is not simply when he has a thought — the question is, is this the appropriate moment for the analyst to make an intervention. The value of an analyst’s thought is not a green light to communicate that thought. The green light for an analyst to communicate his thoughts is at what point an intervention is appropriate. When is it appropriate for the patient to hear the analyst’s thought. My therapist doesn’t seem to consider whether a particular moment is the appropriate moment for her to speak — she will simply speak when she has a thought.

I think about the fact that, routinely, my therapist translates my complaint about her speaking too much into: “You don’t want me to have thoughts. You don’t want me to have separate thoughts from you.” But of course, I don’t complain about her thoughts. In my opinion she can have all the thoughts she wants. I don’t care about her thoughts, per se. The problem is her “speaking” the thoughts at inopportune moments.

This is what is psychoanalytically interesting for me. I seem to be describing the mental state of the infant. Infants cannot contain thoughts. They have an immediate need to “speak” their thoughts. For instance, if an infant is hungry, it cannot contain the thought, “I am hungry.” The infant needs to communicate that feeling into screaming and crying. Whereas if an adult is hungry, she will have the ego capacity to contain that feeling or thought. The adult is able to think the thought “I am hungry” without communicating that thought.

I wonder if these observations say something about my therapist. Also these seem to be Bionian issues. Bion was greatly concerned with “thoughts” and “thinking.” I wonder whether Bionian theory addresses what I am talking about, namely, a patient’s inability to contain his thoughts or the idea that thoughts are not perfected (they don’t really exist as thoughts) until they are communicated. It’s as if my therapist believes at some level that her thoughts are not perfected until she communicates them.

**September 13, 2019**

Had a session with my therapist today. She didn’t say a word the entire time. She generally has a lot to say. At the end of the session, she said my time was up. I said, “Do you want to accept my letter?” She said, “no.” That’s all she said for the entire
hour. I talked for the entire hour, nonstop (I get 60 minute hours). I can do that. I felt like Lucky in *Waiting for Godot*! I became Beckett in analysis with Bion!

Something had to be going on. She doesn’t just stop talking all of a sudden after yakking away for almost 7 months. Maybe she’s been reading my blog. I don’t know. Last week I said to her, “You should check out my Facebook page.” I don’t know.

*September 11, 2019*

Well, what do you know? Salman Akhtar’s “Someday Fantasy” has a tie-in with the Kleinian positions: persecutory anxiety and depressive anxiety. My therapist fancies herself adept at Kleinian work. Seriously? She is a windbag. She cut me off as I started to talk about my “Someday Fantasy.”

*September 8, 2019*

Analysts deal with a lot of uncertainty about their patients. There is so much that an analyst does not know about his patients. A good analyst will refer to the tentative nature of his interventions. Christopher Bollas, an internationally-renowned analyst, writes about how he couches his interventions:

Not so with my therapist. She speaks with certainty. I have called her out on that. On one occasion I said to her, “I feel you speak with too much certainty.” Her reply, “Of course, I speak with certainty. I am a psychoanalyst.”

What does Wikipedia say about Bollas?

Bollas “is one of the most widely read authors in the field of psychoanalysis.” “Or Ezrati, writing in the Israeli newspaper *Haaretz*, remarked: “Some people see Christopher Bollas as one of the two most important living theoreticians in the world of psychoanalysis.”

My therapist is an analyst-in-training. Need I say more?
September 8, 2019

If I criticize my therapist I will get responses such as “You are destroying knowledge” or “You are attacking links.” The response that really drives me up the wall is “I can see you are not ready to accept what I am saying.” She will say something — I will respond: “I don’t understand what you mean” and she will say, “I can see you are not ready to accept what I am saying.” Does it ever occur to her that perhaps she wasn’t clear about what she meant — or that perhaps what she said something doesn’t make any sense? Does it ever occur to her that it would be useful to clarify what she said?

September 6, 2019

I had a session with my therapist yesterday. I mentioned that I had communicated with a University of Maryland professor about my therapy situation and he recommended that I stop seeing her. My therapist responded: “His comments have no value. Besides, he’s not a therapist.” Fine. In all probability he’s not a therapist. He’s a political science professor and the odds are he’s not also a therapist. Fine.

Flash back a few sessions. I had a contentious session with my therapist. I became defensive, “Well, I trained as a lawyer and you’re not a lawyer, so maybe you’re not used to dealing with people like me.” She responded: “You don’t know that. You don’t know that I am not a lawyer.”

Get my point? She reminds me of Trump. She will say whatever supports her position at any particular moment regardless of how inconsistent that position is with prior statements.

More sleaziness?

September 4, 2019
Are some of my problems with my therapist attributable to the following issues – and her failure to recognize these issues?

Your counselor will need to recognize how you are different. Here are some clues a practitioner can use:

A gifted adult may have any or all of the following:

- Advanced vocabulary, existential questions and concerns from an early age, **Multiple in-depth interests**
- A range of deeper than normal emotions and sensitivities (often underground in men), **Advanced analytical abilities, need for precision in fields of interest, perfectionism, rapid thinking, talking and learning**
- Excessive worry, great empathy for all living things, **Unusual insight into oneself**
- Avid reading, unending curiosity and passion for learning (not necessarily for schooling)
- More complex ethical, moral, and justice concerns, **Insight about things that others don’t notice, tendency to argue for fun or for intellectual stimulation**
- Idealism, wit, imagination, creativity, **Questioning authority** and the meaning of life
- Loneliness, anxiety (particularly when bored or during extreme bouts of thinking), existential depression, self-doubt even with seeming successes

**As a child:** Difficulty finding friends, serious schooling frustrations, uneven development, and all of the above

Interesting case in point. Last Thursday, I was talking about having contracted

Last Thursday, I was talking about having contracted scarlet fever when I was three years old. My pediatrician attributed the illness to my drinking spoiled milk that my
mother had allowed me to consume. My therapist said, “But maybe your doctor was wrong. Maybe it wasn’t the milk. Maybe the scarlet fever wasn’t your mother’s fault.”

That aroused my curiosity. When I got home I researched the issue. I first looked into the germ that causes scarlet fever. It’s called *streptococcus pyogenes*. I discovered that research shows that the germ can be found in small amounts in inadequately pasteurized milk. But if the milk is kept refrigerated, there’s no problem consuming the milk because of the minuscule amount of the germ in the milk. But if that milk is left unrefrigerated, the *S. pyogenes* grows to a dangerous level, and if the milk is consumed, there can be disease.

Yesterday, I told my therapist about what I learned. She seemed deflated by what I told her. Then she said, “I find it interesting that you went to the trouble to research that,” implying that I was simply out to get her. To some extent I was “out to get her” — but there were deeper issues. And I told my therapist, “I think my research was a product of my aggression and my creativity. I wanted to aggress against you, but I also was curious about the issues you raised.”

I said, “You know when I was in college I took a course in microbiology (I was a journalism major). I was absolutely fascinated by microbiology. We studied viruses and bacteria and such, and then we studied the diseases caused by these germs. And I would study that material for hours. In fact, my roommate once said to me, ‘What’s that book you’re reading. I see you reading that book all the time!’ So even he noticed that I had a deep interest in this. I have an interest in infectious diseases. You know, Dr. P. has a master’s degree in public health. So that’s another thing we have in common. We’re both interested in infectious diseases.”

I noticed how deflated my therapist looked as I was talking about this. I had invalidated her paranoia.

Was my therapist unable to process my “deep curiosity” about the world, the fact that I have “multiple in-depth interests,” my “tendency to argue for fun or for intellectual stimulation,” and my “questioning authority” (namely my therapist)? (Note how the therapist, a social worker, herself questioned the professional opinion of a medical doctor — she had no problem with doing that herself and yet she was negative about my questioning her opinion.)
Is my therapist able to work with gifted patients — or is she too insecure to work with gifted patients? Will she tend to experience aspects of my giftedness as my “attacks” on her?

My therapist complains that I “pick fights” with her because I complain that she fails “to listen to me with evenly hovering attention,” she doesn’t allow me to express myself, and she doesn’t permit free association.

It’s as if my therapist erases the difference between, one the one hand, my thoughtful concerns, and, on the other, a patient calling his therapist an “asshole.” That’s basically what she’s doing. As I wrote before, “A fellow analyst reading her process notes might very well form the opinion that ‘picking fights’ refers to my heated and personally abusive attacks, when in fact all that I expressed was my discomfort with her technique, using appropriately descriptive language. If I say, ‘I think you talk too much’ — her interpretation is ‘You are picking a fight with me.’ Once again, these distortions of objective reality are what we find in persecutory states (and political dictatorships—in a political dictatorship, if a disgruntled citizen writes a reasonable letter of complaint to a government official he might well be charged with sedition).”

I find that offensive. And I find it psychologically manipulative that she seems to try to turn herself into a victim of my “aggression” simply because I voice my concerns about her work in a respectful and thoughtful manner. What patients complain about the lack of “evenly hovering attention?”

The bottom line is she doesn’t like being criticized. That’s all. And a lot of that has to do with her sense that she’s an outstanding “psychoanalyst.” I don’t know how many times she has worked in the statement, “I am a psychoanalyst.” Can you imagine David Callet repeatedly telling a client, “I am a lawyer.” What is up with that?

This issue reminds me so much of the interaction between President Trump and CNN’s Jim Acosta last November. Acosta asked Trump a question he didn’t like, so Trump attacks him: ” You are a rude, terrible person.” Notice how Trump deflected attention away from the content of Acosta’s question to a distorted depiction of Acosta’s behavior. That’s exactly what I said about my therapist. She transforms my thoughts into behaviors — because she doesn’t like the content of my thoughts.
She may be a narcissist, but I don’t know.

**August 28, 2019**

Yesterday I had a therapy session. I went into the whole history of how I was working at a law firm and the managers had concerns about my mental health. I explained that in a legal document the firm said it had consulted a practicing psychiatrist about me and the psychiatrist offered the opinion that, based on the managers’ description, I appeared to have emotional/psychological issues of a paranoid nature and that people like me can become violent.

I then explained that I later telephoned the psychiatrist and she flatly denied that she had any contact with the firm. She flatly denied talking to one of the attorneys who said that he spoke with her. I also said, “She even wrote a letter to me stating that she never talked to one of the attorneys who said he talked to her.”

My therapist embarked on a defense of the psychiatrist. My therapist said that the psychiatrist’s oral and written statements to me settled the matter: the psychiatrist did not talk to the employer.

I then said: “So you’re saying my employer lied.” She said, “No. I’m not saying that. I am not saying they lied.”

Am I crazy or just stupid?

I always thought that if person A alleges in a sworn statement that he did certain things and that person B did certain things in response — and if person B denies that he ever did those things (in writing) then, logically, either person A or person B is lying. Isn’t that a logical deduction?

My therapist doesn’t understand that there are implications to what she says. Yes, she did not expressly say my employer lied, but isn’t she implicitly saying that nonetheless?

What does it say about my therapist’s integrity that she would say that — that she would hold these conflicted opinions? Is this more evidence of her sleaziness? I wonder.
August 26, 2019

Therapy Session 8-22-2019

I gave my therapist a copy of a paper by Melanie Klein, “On the Sense of Loneliness.” I explained: “I wasn’t looking for the paper. I was reading a biography of Melanie Klein by Phyllis Grosskurth and she mentioned this paper and talked about it. I was intrigued. Grosskurth described it as a “beautiful paper” so I wanted to read it. It just happened that the paper was on the Internet, so I made a copy.” I read to the therapist a passage from the paper about imaginary twinship:

“The longing to understand oneself is also bound up with the need to be understood by the internalized good object. One expression of this longing is the universal phantasy of having a twin . . . . This twin figure [] represents those un-understood and split off parts which the individual is longing to regain, in the hope of achieving wholeness and complete understanding; they are sometimes felt to bethe ideal parts. At other times the twin also represents an entirely reliable, in fact, idealized internal object.” Klein, M. “The Sense of Loneliness.”

There was no indication of the therapist’s emotional reaction to my bringing in a copy of the paper. The therapist did say, “I never read the paper. It’s not one of her more well known papers.” The next day (August 23), the therapist confabulated that I had gone out of my way to acquire a copy of Melanie Klein’s paper and had carefully made a copy — which seemed paranoid (my investing a lot of energy into making the copy). In fact, the therapist’s confabulation was clearly contradicted by my express report the day before, namely, that I found the paper on the Internet after just happening to read a biography of Klein. The therapist began to tell me her interpretation of my going out of my way to copy the paper when I interrupted, “No. I simply made the copy from the Internet. There’s a copy of the paper on the Internet.” Did my act of bringing in Klein’s paper, which the therapist never read, bring up feelings of shame and humiliation in the therapist? I had exposed a gap in her knowledge. She seems to take pride in her knowledge of Klein.

In the paper Klein talks about a patient’s idealized internal object and the patient’s creation of an imaginary twin that will provide perfect empathy for the patient (a derivative of the internalized idealized object). Klein’s observations about township can be viewed concretely as relating to a triad: parent (idealized parental object) and
two children (patient and fantasied twin), that is, the same triad that makes for
sibling rivalry — rivalrous feelings between two siblings vis-a-vis an (idealized) parent.

I talked with the therapist about the session being contentious. We got into a good-
natured debate about the meaning of fantasy and reality.

THERAPIST: You are being contentious with me. I am not being contentious with
you.

PATIENT: In my fantasy you are being contentious with me.

I said, “You know at this session I am thinking of both of us as opposing lawyers in a
court room. We are each arguing our side.” Holding up Klein’s paper, I laughed and
said figuratively, “I even came armed with a legal brief.”

Then late in the session I talked about Wilfred Bion. “You know, I came across a
YouTube video of Bion on the Internet. It’s an hour long. I was intrigued. He
seemed like an emotionally detached person. He seemed intellectual. That’s the type
of therapist I would like to have. I wish Bion could be my therapist.”

Significantly, the therapist replied: “Me too. Me too.”

I found the therapist’s comment striking and possibly revealing. It suggested sibling
rivalry on the part of the therapist. Bion was the idealized father, and the therapist
seemed to be fighting with me over having him as the idealized father. That’s striking
because the whole content of the session seemed to relate in some way to sibling
rivalry between me and the therapist. The contentiousness, my exposing her lack of
knowledge about Klein’s paper, my exposing her lack of knowledge about Klein’s
comments about twinship fantasy.

**Therapy Session: Next day 8-23-2019**

I offered the thought that at our previous session (8-22) the therapist had been
rivalrous with me and that her statement (“Me too!) in relation to Bion was
countertransference suggesting she sought an idealized relationship with Bion in
competition with me. She denied my interpretation and became defensive. She then
turned to me. “Tell me how jealousy and rivalry play a part in your life?”
Possible interpretations: (1) both the therapist and I are rivalrous with each other; (2) only I am rivalrous with her; (3) only she is rivalrous with me.

But a fourth interpretation is also possible and possibly significant. That interpretation is that I induced feelings of rivalry in the therapist through my projective identification. Did I attempt to induce feelings of jealousy in her? Were those feelings coming from me at the outset?

The psychiatrist Gabriel Margret Hobday, M.D. has pertinent comments:

“Countertransference enactment. In the 1990s, a number of American ego psychologists began contributing papers on the topic of countertransference enactment in therapy. The term gradually took on a meaning quite similar to projective identification. The fundamental idea was that “enactments occur when an attempt to actualize the transference fantasy elicits a countertransference reaction.” . . . Roughton described this as actualization: subtle forms of manipulation on the part of the patient that induce the therapist to act or to communicate in a slightly special way or to assume a particular role with the patient that silently gratifies the transference wish or, conversely, defends against such a wish. Hobday, G.M., “Of Two Minds,” Psychiatric Times.

August 23, 2019

At my therapy session today I shared a quote by Wilfred Bion: “I’m no more Kleinian than Melanie was. She always thought of herself as a Freudian, but Anna (Freud) saw to it that she would be labeled ‘Kleinian.’”

My therapist responded: “That’s true. Bion did not consider himself a Kleinian. He wanted to be independent of any school of psychoanalysis. In fact, he moved to California ‘to get away from Melanie Klein’.”

I found the therapist’s comment striking.

Several weeks ago, I had related to my therapist an anecdote I read about Klein in Jeffrey Masson’s book, Final Analysis: The Making and Unmaking of a Psychoanalyst, about his experiences in analytic training and after.
Masson talked about his disdain for Klein’s analytic theories and her clinical work. He mentioned an anecdote about Klein and one of her child patients. The boy became so exasperated with Klein at a session, that he ran out of the room and into Klein’s garden “to get away from Melanie Klein.”

Tellingly, my therapist stood up for Klein. She hypothesized (or confabulated) that the boy was experiencing guilt feelings in relation to Klein, and he was trying to flee from his own guilt feelings. (How did my therapist even come up with that?)

With Bion, Bion seemed to be the “good object” fleeing the domineering Klein (and Melanie Klein was notably domineering), wanting to assert his autonomy; in the case of the boy (Klein’s patient) – he was struggling with guilt in his relations with Klein.

In Klein’s world, was my therapist perhaps showing paranoid-schizoid anxiety in her apparent split image of Klein?

August 22, 2019

I’m no more Kleinian than Melanie was. She always thought of herself as a Freudian, but Anna (Freud) saw to it that she would be labeled “Kleinian.”

– Wilfred Bion

Melanie Klein wrote the following about twinship fantasy: “The longing to understand oneself is also bound up with the need to be understood by the internalized good object. One expression of this longing is the universal phantasy of having a twin . . . . This twin figure [] represents those un-understood and split off parts which the individual is longing to regain, in the hope of achieving wholeness and complete understanding; they are sometimes felt to be the ideal parts. At other times the twin also represents an entirely reliable, in fact, idealized internal object.” Klein, M. “The Sense of Loneliness.”

Is Klein saying there is a connection between the desire for twinship and the desire for self-understanding?
I have a remote association to Bela Grunberger’s (and others’) ideas about the concept of “narcissistic elation.” (Grunberger was a Freudian. He once said: “There are two kinds of analysis. There is Freudian analysis, and there is everything else, which is opposed to it, and which makes use of everything then to be used against analysis. This is because analysis makes the unconscious conscious, and this is something that people cannot tolerate.”)

In Grunberger’s coinage narcissistic elation is “the narcissistic situation of the primal self in narcissistic union with the mother.” It is the state of prenatal beatitude, which according to Grunberger characterizes the life of the fetus: a state of megalomaniacal happiness amounting to a perfect homeostasis, devoid of needs or desires. The ideal here is bliss experienced in absolute withdrawal from the object and from the outside world. Narcissistic elation is at once the memory of this unique and privileged state of elation; a sense of well-being of completeness and omnipotence linked to that memory, and pride in having experienced this state, pride in its (illusory) oneness. Narcissistic elation is characteristic of an object relationship that is played out, in its negative version, as a state of splendid isolation, and, in its positive version, as a desperate quest for fusion with the other, for a mirror-image relationship. Perhaps we can compare the “mirror-image relationship” described by Grunberger with the “twinship” relationship described by Klein.

The French analyst Chasseguet-Smirgel (Grunberger’s wife, by the way) claimed that “it is indeed therefore narcissistic elation, the meeting of ego and ideal, that dissolves the superego.” Is this related to Freud’s observations about “borrowed guilt” — that amelioration of borrowed guilt can be obtained in the analytic situation in which “the personality of the analyst allows of the patient’s putting him in the place of his ego ideal”? Is Freud talking about a meeting of the analyst’s ego ideal with the patient’s ego, thus dissolving the patient’s superego? That is, is there a relationship between the affect of “narcissistic elation” (i.e., the “illusion of oneness” described by Grunberger) and the amelioration of borrowed guilt described by Freud? Can my feelings about Dr. P. be compared with narcissistic elation?

But there is a further significant parallel between Klein and the Freudians:

Klein links twinship fantasy with the desire for self-understanding. With regard to self-understanding, analysts believe that narcissistic elation may be reactivated within a therapeutic context. Edmund Bergler [“Bergler was ‘among the most prolific
Freudian theoreticians after Freud himself’”] wrote of “the narcissistic elation that comes from self-understanding”; while Herbert Rosenfeld [a leading Kleinian] described what he called the re-emergence of “narcissistic omnipotent object relations . . . in the clinical situation.”

Somewhat similarly, Lacan spoke of “the megalomaniac ebriety which...[i]s the index of the termination of the analysis in present practice.”

Dorothy Burlingham’s observations about the twinship fantasy of latency are pertinent, it seems to me.

Klein said that twin fantasy is a mix of depressive and persecutory anxiety. In some sense Burlingham (a Freudian) is saying the same thing. Burlingham said that twin fantasy is a product of the child’s destructive impulses against the parents — perhaps, Klein would see these attacks as motivated by infantile persecutory anxiety — and that the fantasy twin represents the child’s ego ideal, in Kleinian terms, that is, the twin represents the child’s internalized idealized good object (depressive anxiety).

Burlingham wrote: “A common daydream which in spite of its frequency has received very little attention to-date is the fantasy of possessing a twin. It is a conscious fantasy, built up in the latency period as the result of disappointment by the parents — and retaliatory destructive impulses directed by the child in fantasy against the parents — in the oedipus situation, in the child’s search for a partner who will give him all the attention, love and companionship he desires and who will provide an escape from loneliness and solitude. The same emotional conditions are the basis of the family romance. In that well-known daydream the child in the latency period develops fantasies of having a better, kinder and worthier family than his own, which has so bitterly disappointed and disillusioned him. The parents have been unable to gratify the child’s instinctual wishes; in disappointment his love turns to hate; he now despises his family and, in revenge, turns against it. He has death-wishes against the former love-objects, and as a result feels alone and forsaken in the world. Burlingham, D.T. “The Fantasy of Having a Twin.” The Psychoanalytic Study of the Child. Vol. 1 at 205 (1945). A further element in many daydreams of having a twin is that of the imaginary twin being a complement to the daydreamer. The latter endows his twin with all the qualities and talents that he misses in himself and desires for himself. The twin thus represents his superego [I think she means “ego ideal” — in Kleinian terms, the internalized idealized good object ].” Id. at 209.
Again: Is there a parallel between Klein’s linking of “twinship” with “the desire for self-understanding,” on the one hand, and the Freudian view (at least that espoused by Grunberger and others) that there can be a connection between a “desperate quest for fusion with another” (a type of twinship fantasy) and “a quest for self-understanding?”

And more concretely, as it pertains to me, is there a connection between my obsessive self-analysis and my obsessive preoccupation with Dr. P.? And what does that say about me?

**APPENDIX: Freud’s footnote about the borrowed sense guilt in The Ego and the Id.**

“The battle with the obstacle of an unconscious sense of guilt is not made easy for the analyst. Nothing can be done against it directly, and nothing indirectly but the slow procedure of unmasking its unconscious repressed roots, and of thus gradually changing it into a conscious sense of guilt. One has a special opportunity for influencing it when this unconscious sense of guilt is a ‘borrowed’ one – when it is the product of an identification with some other person who was once the object of an erotic cathexis. A sense of guilt that has been adopted in this way is often the sole remaining trace of the abandoned love-relation and not at all easy to recognize as such. (The likeness between this process and what happens in melancholia is unmistakable.) If one can unmask this former object-cathexis behind the unconscious sense of guilt, the therapeutic success is often brilliant, but otherwise the outcome of one’s efforts is by no means certain. It depends principally on the intensity of the sense of guilt; there is often no counteracting force of a similar order of strength which the treatment can oppose to it. Perhaps it may depend, too, on whether the personality of the analyst allows of the patient’s putting him in the place of his ego ideal, and this involves a temptation for the analyst to play the part of prophet, savior and redeemer to the patient. Since the rules of analysis are diametrically opposed to the physician’s making use of his personality in any such manner, it must be honestly confessed that here we have another limitation to the effectiveness of analysis; after all, analysis does not set out to make pathological reactions impossible, but to give the patient’s ego freedom to decide one way or the other.”

*August 17, 2019*
THERAPY SESSION: August 15, 2019

Early in the session, I mentioned to my therapist out of the blue, "I was listening to the Bruckner Seventh Symphony this morning before I came here. I had some time, so I was sitting on the bench in front of my building listening to my iPod." A non-analytic therapist would see that as a trivial observation that has no psychological meaning. In fact, I thought that myself when I told my therapist that. I thought, "Why did I have to tell my therapist that?"

Much later in the session, I was talking about my vacation to Atlantic City (August 5-9). I said, "I never told you this. Maybe I should have mentioned this when I was talking about my vacation. But I still remember on August 5, 2003 my one-time psychiatrist, Dr. Sack died. He was on his vacation. He was 69 years old. He went on vacation, and all of a sudden he just died of a heart attack. I was emotionally crushed by that. I remember when I found out, I just laid on my couch and listened to the slow movement of the Beethoven Ninth Symphony again and again. For over an hour I guess. Just the same music again and again. The music is kind of sad and wistful. And, you know, I was working on my book at that time. You know, the book with all the quotes. And I actually added material to the book as a homage to Dr. Sack."

"Then a light bulb went off in my mind. "You know, that's related to what I said earlier. When I was talking about listening to the Bruckner Seventh Symphony this morning on my iPod. When Bruckner was was writing the slow movement, the second movement, he had a premonition of Wagner's death. He idolized Wagner. And he wrote a homage to Wagner in the slow movement of the symphony. That's just like what I did when Dr. Sack died. I included a homage to Dr. Sack in my book."

"Bruckner seems to have had a premonition of Wagner's death and as it happened was composing the Adagio [slow movement] of the Symphony No. 7 on Feb. 14, 1883, when the news arrived that his idol had died the day before. The movement, which already had a definitely elegiac tone, turned into a kind of funeral oration."

It was no mere accident that I referred to the Bruckner 7th Symphony at the opening of the session. In fact, I might go so far as to say it was no mere accident that I chose to listen to the Bruckner 7th this morning. I haven't listened to that music in a long time.
So what did my therapist say? "Oh, the Beethoven 9th is a very dramatic work. It contains the famous 'Freude, schöner Götterfunken.'" I said, "No, that's the fourth movement. I was talking about the third movement, which is kind of sad and wistful." Is that what that portion of the session was about? Is that all my therapist picked up as the import of what I was talking about? Symbolically, what I was talking about was death, loss, mourning, sadness, and "passive surrender to an idealized object." These issues have nothing to do with the Beethoven 9th being "dramatic" or the fact that it includes the famous "Ode to Joy" ("Freude schöner Götterfunken") of all things! As is typical of the therapist, she fragments my narrative; she comments on the individual fragments of my narrative as if they were not an integral part of a whole.

Psychoanalytically, it's interesting that my father died of heart disease at age 69, Dr. Sack died at age 69 of heart disease while on vacation, and Wagner died of heart disease at age 69 (while on vacation, no less). And you can see how my mind didn't want to think about Dr. Sack's death (or my father's death) - and instead displaced my psychic pain onto Wagner and Bruckner.

KLEINIAN ISSUES:

Comments about Dr. Sack:

Mourning and Loss. Issues of mourning and loss, in Klein's view, relate to depressive anxiety. Klein, M. "Mourning and Its Relation to Manic-Depressive States." Klein traced adult feelings of mourning and loss to the infant's relationship with mother. Klein's "contention is that the child goes through states of mind comparable to the mourning of the adult, or rather, that this early mourning is revved whenever grief is experienced later in life." Id. Klein wrote: "The object which is being mourned is the mother's breast and all that the breast and the milk have come to stand for in the infant's mind: namely, love goodness and security. All these are felt by the baby to be lost [at the time of weaning], and lost as a result of his own uncontrollable greedy and destructive phantasies and impulses against his mother's breasts. Further distress about impending loss (this time of both parents) arises out of the Oedipus situation . . . The sorrow and concern about the feared loss of the 'good' objects . . . is, in my experience, the deepest source of painful conflicts . . . in the child's relations to people in general." Id.

Klein proposed that sadness is a "feeling central to the depressive position." Hinshelwood, R.D., "The Depressive Position." For Klein, "sadness related to feelings about the damaged loved object, both the external object and the internal one." Id.
The therapist failed to explore the feelings (and related conflicts) apparently related to the depressive position and simply commented on the Beethoven Ninth as a dramatic symphony that contained the famous "Ode to Joy."

**Reparative Strategies.** I mentioned how I added a homage to Dr. Sack in the book I was writing in the year 2003, at the time of his death. The Kleinian analyst, Hanna Segal theorized that creativity emerges out of the depressive position. The concept of the depressive position, as originally described by Klein, allows for the possibility to discuss the idea of an internal creative world. Betty, N.S. “Creativity: The Adaptive Aspects of Insecure Attachment.” Essentially, the wish to restore the whole loved object, which the individual believes has been lost because of his own attacks, induces guilt that fuels the wish to make reparations. *Id.* “This wish to restore and re-create is the basis of later sublimation and creativity (Segal).” *Id.* According to Segal, as long as depressive anxiety can be tolerated by the ego and the sense of psychic reality retained, depressive phantasies stimulate the wish to repair and restore. *Id.* Importantly, Segal made the following critical observation about the link between depressive anxiety and creativity: “I have quoted [the novelist, Marcel] Proust at length because he reveals such an acute awareness of what I believe is present in the unconscious of all artists: namely, that all creation is really a re-creation of a once loved and once whole, but now lost and ruined object, a ruined internal world and self. It is when the world within us is destroyed, when it is dead and loveless, when our loved ones are in fragments, and we ourselves are in helpless despair, it is then that we must recreate our world anew, reassemble the pieces, infuse life into dead fragments, re-create life. . . . [T]he wish to create is rooted in the depressive position and the capacity to create depends on a successful working through of it[.]” Segal, H. “A Psychoanalytic Approach to Aesthetics.”

Perhaps the subject matter of the material I added to my book in the days after Dr. Sack's death in 2003 is analytically revealing. I merged the themes of Wagner's, *Tristan und Isolde* – an opera about a tragic and tortured love – with the destruction by atom bomb of the Japanese city of Hiroshima at the end of World War II, that is, the themes of a “world destroyed,” of a city “lost and ruined.”

The therapist failed to explore my use of reparative strategies – such as the use of writing – to deal with depressive anxiety and simply commented on the Beethoven Ninth as a dramatic symphony that contained the famous "Ode to Joy." Something that seems to have eluded the therapist throughout my work with her is the extent to which the letters I write about my therapy sessions are a reparative strategy rooted in depressive anxiety. That would be a rich area of inquiry since I invest so much mental energy in my letter writing. To the extent my letters represent my attempt to
expand knowledge (in a Bionian sense), perhaps my letters are related to depressive anxiety.

**Idealization.** For me, Dr. Sack was an idealized object. My psychological relationship with him represented the "passive surrender to an idealized object." One might suppose that my comments about Dr. Sack related in some way to my obsession with Dr. P-- who was also the subject of my writings. Also, how did my idealization of Dr. Sack relate to my idealization of my father (Dr. Sack appears to have been a displacement object for me – a stand in for my father)? How did my comments about Dr. Sack at this session relate to my dream write-ups that feature associations to my father? (See, e.g., The Dream of Eggs and Lox).

Manic defense (such as idealization) permits the evasion of some bit of psychic reality or mental pain. "Manic defenses represent a group of maneuvers whose use begins to develop in the latter half of the first year of life and continue with great prominence in many people throughout the lifespan. Their central feature is that they are aimed at evading the pains attendant to loving and needing an object who also makes you angry and want to hurt them. In other words, they aim to evade the pains of the depressive position, and most particularly guilt, and thus effectively denying some aspect of psychic reality." Minnick, C.L., "The Manic Defense." Donald Winnicott noted that the use of manic defense (such as idealization) is typical of individuals who dread sadness and are unable to mourn.

The therapist failed to explore feelings of idealization and guilt (and related conflicts) in my comments about Dr. Sack and simply commented on the Beethoven Ninth as a dramatic symphony that contained the famous "Ode to Joy." The therapist failed to explore the relationship between my feelings about Dr. Sack and Dr. P-- as displacement objects – that is, as stand ins for my father.

**Transference Matter and Possible Depressive Anxiety:**

At a later point in the session I talked about a fantasy I had about my therapist. I said, "You know, sometimes I think how awful it must be for you doing this work. Hour after hour, you have people telling you their stories and you have to listen to them. Sometimes I think you must be in agony sitting here."

The therapist responded: "Maybe that's an example of you forcing your distressed feelings into me."
The therapist's comment was ambiguous. Was she talking about projective identification rooted in persecutory anxiety or projective identification rooted in depressive anxiety? It is well to remember that in the depressive position, projective identification is used to empathize with others, moving parts of the self into the other person in order to understand them. That is to say, projective identification (forcing one's feelings into another) can be based on empathy or a maneuver used to attack a bad object.

Is it possible that I had feelings of remorse and guilt about harming the therapist through my work with her: the subjective perception that my weekly "stories" (my clinical narrative) burdened or overwhelmed her, thereby damaging her?

In failing to see the possible depressive anxiety underlying my fantasy about the therapist's "agony," she failed to "link" these comments about her to the depressive anxiety underlying my earlier comments about Dr. Sack.

The therapist failed to explore the possible depressive anxiety underlying my transference, it's linkage to previous material in the session (concerning Dr. Sack) -thereby once again exposing the fact that the therapist fragments my narrative into discrete segments that she comments on seriatim. In so doing, the therapist once again exposed her failure to have internalized the psychoanalytic precept of psychic determinism (the notion that everything I talk about in a session is related) and her inability to work with free association.

Also, the therapist failed to explore the possible mixed feelings in my fantasy about her, thereby exposing the seeming "black and white" nature of her thinking about the Kleinian positions: "If a person's aggressive impulses are strong, unconscious phantasies are experiences of attacks upon objects, parents, and so on, who are thereby damaged. When they are mingled with hatred, love seems weaker and threatened, and so do the loved objects. However, because they are also loved, it gives the characteristic agonized position in which the person fears for those who are under attack. We have seen examples where conflicted and paranoid states are internalized in hatred - that is, with biting and damage; then the internal state is very troubled, because it now contains an object that may be hostile (as in the paranoid states of the example of The man who assaulted his buttocks and The woman with a devil inside - pp. 66, 74). If, instead, love is mixed in, then the object may be experienced as damaged, insecure and no longer capable of giving protection and well-being. It is this damaged internal object which gives the characteristic mixed
feelings of the depressive position. Hinshelwood, R.D., "The Depressive Position (emphasis added)."

All I got from the therapist was the fact that the Beethoven Ninth is a dramatic symphony that contains the famous "Ode to Joy."

**August 12, 2019**

**THERAPY SESSION: August 2, 2019**

This was the last session preceding my vacation in Atlantic City, a one-week stay from Monday August 5, 2019 to Friday August 9, 2019. At a previous session I talked about my anxiety about going to Atlantic City — a nameless, vague anxiety that I was experiencing but was unable to attach to any specific aspect of the trip.

On Monday July 29, 2019, I wrote the following on my blog:

My therapist sees meaning in everything I say — and that meaning always relates to her in some way.

Last week, when I entered the office, I sat down and commented on the little items she had on a table: a paperweight, a book, other things. I said, “You re-arranged the items on the table.” After some give and take my therapist seemed to agree when I said, “Maybe I am having anxiety about going on vacation and having to re-arrange my schedule with you.” My therapist elaborated this notion. I then said, “Well, what I think I was doing was showing off. I wanted to show you how perceptive I am.”

Typically, my therapist focuses on loss of a supportive relationship (as with going on vacation), while I focus on narcissism. She never gets to the narcissism. She is immersed in an anaclitic world while I am immersed in an introjective world.

I associate to a paper by Sidney Blatt:

The type of person described by Freud (1916) as “wrecked by success” is likely to have an introjective depression in which there is guilt over phallic strivings and symbolic oedipal triumphs. But success can also precipitate an anaclitic depression when the success involves the loss of a supportive relationship. The disturbances in both types of depression can be relatively mild or reach psychotic proportions. Hypomanic reactions can also occur in both types of
depression; but in anaclitic depression this would consist of intense seeking and clinging to objects, while in introjective depression there would be frantic attempts to demonstrate strength, material accomplishments, power, physical attractiveness, intellectual capacity, or creativity as a way of seeking recognition and avoiding punishment and criticism. Compensatory and restitutive hypomanic reactions in introjective depression do not require direct and physical contact with the object, but rather involve more symbolic derivatives such as recognition, approval, and material possessions.” Thus, the anaclitic patient on taking a vacation break from therapy might focus on the loss of the supportive therapeutic relationship, while an introjective patient might defend against his anxiety by demonstrating intellectual capacity or by, perhaps, “showing off.”

I can’t deny the therapist’s interpretation. It may be true. But it is so shallow. If she had asked me: “Do you have anxiety about going on vacation, I would have said, “Yes.” The anxiety is not housed in a warded off part of my mind. I have clear access to it. So what is she revealing in her “interpretation?” She’s telling me what I knew in the first place. I have anxiety about going on vacation.

At one point in the August 2 session my therapist, apparently attempting to trigger anxiety in me for therapeutic purposes, said: “All the people you knew in Atlantic City when you were a kid are probably now dead.” I said (humorously): “It’s the same ocean.” She laughed. The therapist’s comment was actually a revealing projection on her part. The therapist seems unable to get inside the mental world of an introjective patient. She continually projects anaclitic concerns onto me. An anaclitic patient would be concerned about lost ties to people through death. But an introjective person does not have the same concerns for relatedness. The introjective individual is concerned with Oedipal issues, guilt and identity definition as well as the issues of industriousness, work satisfaction, and accomplishment: issues related to vocation and career, and by inference, the coherence of identity. These are characteristic introjective concerns related to autonomy, self-worth, and identity as opposed to anaclitic concerns of intimacy and interpersonal mutuality. What does it say about the therapist’s own personality that she cannot process introjective concerns in a patient? The therapist’s difficulty in processing introjective concerns has implications for her ability to work with depressive anxiety (in Kleinian theory) in which guilt and Oedipal issues are prominent. For Klein, the Oedipus complex and the depressive position are closely linked.

At the opening of the August 2 session I asked the therapist to accept a copy of an ethics complaint I had filed against my previous therapist. That ethics complaint
referred to an apparently perjured sworn statement lodged years earlier by my last employer against me.

My therapist characterized my ethics complaint against her social work colleague (my previous therapist) as a “violent act. Perhaps my therapist’s sense of professional loyalty was a factor in her assessment of my behavior. Out of the blue I said, “Lenin was violent.” The therapist ignored the symbolic content (and psychoanalytic significance) of my statement about Lenin and focused on the literal, saying “You’re not Lenin.” This is perhaps what Bion calls negative K. In effect, the therapist destroyed a knowledge link, refusing to inquire into the symbolic aspect of my statement. In effect, the therapist was “destroying knowledge,” something the therapist accuses me of doing. (At the previous session, I said that the therapist relied too much on “labels” of me. She thereupon accused me of “destroying knowledge,” or in Bion’s language, I was engaging in negative K.)

A seasoned analyst who had internalized the psychoanalytic precept of psychic determinism would have thought about how my incongruous reference to Lenin related to the theme that opened the session, namely, my act of proffering a copy of the ethics complaint I had instituted against my previous therapist. But my therapist has not internalized the precept of psychic determinism and continually fragments my narrative. In my therapist’s mind the ethics complaint was a discrete fact and the reference to Lenin was a discrete fact — these discrete facts were not related. The therapist is consistently oblivious to context, which is a bedrock of psychoanalytic thinking. It appears that my therapist is unable to work with free association.

Psychic determinism is a type of determinism that theorizes that all mental processes are not spontaneous but are determined by the unconscious or preexisting mental complexes. It relies on the causality principle applied to psychic occurrences in which nothing happens by chance or by accidental arbitrary ways. It is one of the central concepts of psychoanalysis. Thus, slips of the tongue, forgetting an individual’s name, and any other verbal associations or mistakes are assumed to have psychological meaning. Psychoanalytic therapists will generally probe clients and have them elaborate on why something “popped into” their head [like a patient saying incongruously during a session, “Lenin was violent”] or why they may have forgotten someone’s name rather than ignoring the material. The therapist then analyzes this discussion for clues revealing unconscious connections to the slip of verbal association. Psychic determinism is related to the overarching concept of determinism, specifically in terms of human actions. Therapists who adhere to the belief in psychic determinism assume that human action and decisions are
predetermined and are not necessarily under their own control. Free association is based on the concept of psychic determinism, the notion that, as Freud said, everything a patient says in a session is “strictly determined.” My therapist seems oblivious to psychic determinism.

The therapist’s difficulty working with free association is detrimental to therapeutic progress in a pathologically introjective patient. Research data supports the view that free association is vital to the therapeutic progress of introjective, as opposed to anaclitic, patients. Sidney Blatt’s research found that: “The increase in associational activity in PSA [psychoanalysis], its decrease in SEP [supportive-expressive psychotherapy], and their possible roles in the treatment processes studied by the MPRP [Menninger Psychotherapy Research Project] are consistent with clinical observations and expectations, as well as with recent findings by Fertuck et al. that therapeutic progress in seriously disturbed treatment-resistant anaclitic inpatients in the Riggs Yale Project [RYP] was significantly associated with a reduction in referential activity, while progress in introjective patients was significantly associated with its increase. Fertuck et al. assessed changes in patients’ capacity for referential activity (Bucci 1984)—the degree to which connections are established between nonverbal systems and a communicative verbal code so that emotional experiences are translated into language capable of provoking corresponding experiences in a listener—using computer analyses of linguistic dimensions in narratives given to a standard set of TAT cards at intake and much later in the treatment process. In the intensive, psychoanalytically oriented inpatient treatment of seriously disturbed treatment-resistant patients in the RYP (dynamically oriented psychotherapy at least four times weekly), therapeutic progress in introjective patients was significantly associated with an increase in referential activity, while progress in anaclitic patients was significantly associated with its decrease.” Again: “Psychoanalysis, by contrast, is more effective in decreasing maladaptive interpersonal tendencies, as well as in facilitating the development of adaptive interpersonal capacities, primarily with the more distant and isolated introjective patients, who are more distant and well-defended, because the explorations and interpretations in psychoanalysis more fully engage them. We assumed that the uncovering process of exploration and interpretation in psychoanalysis would result in a significant increase in associative activity during treatment.” And again: “These findings by Fertuck et al., consistent with the results of our analyses of data from the MPRP, suggest that anaclitic patients do better in a treatment process that inhibits associational activity, whereas introjective patients do better in a treatment that facilitates it.” My therapist’s impaired ability to allow a patient to employ free association (which might be related to her own predominantly anaclitic concerns)
minimizes my ability to gain therapeutic benefit from treatment. My statement, “Lenin was violent” was an association. The therapist’s matter-of-fact response, “You’re not Lenin” was an inappropriate and uninformed intervention that sabotaged an inquiry into the associational meaning of my reference — namely, the relationship between “Lenin” and the “ethics complaint.”

Be that as it may.

The therapist refused to accept the copy of the ethics complaint that I proffered. I explained that I was trying to “link up” the ethics complaint against my former therapist to my last employer in a Machiavellian scheme to collaterally attack my job termination from 30 years earlier, in 1991. The therapist said that she didn’t want “to collude” in my games and therefore didn’t want to accept or read the ethics complaint. She said, “I don’t want to be drawn into this.”

At a later point in the session, a light bulb went off in my mind. I said incongruously, “I’m taking a train to Atlantic City. That’s how I am getting there. I am taking a train. That reminds of Lenin!! You remember I mentioned Lenin earlier in the session.”

I note incidentally, that traveling — as en route to a vacation site — can trigger introjective anxiety relating to work, career success, and creativity. Erik Erikson observed about Freud in his book *Insight and Responsibility*: “During [the 1890s] Freud [then in his forties and embarking on the discoveries that would lead to psychoanalysis] at times expressed some despair and confessed to some neurotic symptoms which reveal phenomenological aspects of a creative crisis. He suffered from a “railroad phobia” and from acute fears of an early death—both symptoms of an over-concern with the all too rapid passage of time. “Railroad phobia” is an awkwardly clinical way of translating *Reisefieber* — a feverish combination of pleasant excitement and anxiety. But it all meant, it seems, on more than one level that he was ‘coming too late,’ that he was ‘missing the train,’ that he would perish before reaching some ‘promised land.’ He could not see how he could complete what he had visualized if every single step took so much ‘work, time and error.’”

At the August 2 session I continued: “Well, during World War I Lenin lived in exile in Zurich, Switzerland. He was a known revolutionary. The Germans had an idea in early 1917, a Machiavellian scheme. ‘Why not transport Lenin back to Russia. We
know what he’ll do. He’ll engage in revolutionary activities. He’ll cause trouble for
the Russian government (which was fighting Germany in the war). So the Germans
put Lenin on a sealed train in Zurich and had him shipped off to Russia.” The
Germans foresaw that if Lenin got back to Russia, he would undertake efforts to
destabilize the Imperial Russian government which might ultimately lead to Russia’s
withdrawal from the war — which would be in Germany’s interest. Winston
Churchill later compared the German plan to a kind of germ warfare: “Reflecting on
these events years later, Winston Churchill would compare Ulyanov, or Lenin, as he
styled himself, to a “plague bacillus” that had been introduced into a body at
precisely the moment it could do the most harm. The train injected the bacillus late
at night, when it arrived and was greeted by a delirious crowd. The next day, Lenin
was off and running, speaking and writing at a frantic pace, rejecting compromise,
relentlessly pulling the Revolution toward his hard Bolshevik line.” By the end of
1917, Lenin and the Bolsheviks had toppled the Imperial Russian Government.

I said to the therapist, “I think I know why I referred to Lenin earlier. I am like the
German government trying to manipulate people to do my bidding. Just as the
German government was using Lenin to destabilize Russia, I am attempting to
manipulate my previous therapist, by way of my ethics complaint, to advise the
authorities that the sworn statement issued by my previous employer against me years
ago was perjured. Last time I mentioned that I communicated to one of the
Directors (Wayne H. Rusch, Esq.) of the Clinic where I saw my last therapist. You
said to me, ‘But that guy doesn’t even know you.’ Well, the reason I did that is that I
wanted him to contact the FBI.” [In effect, I was trying to manipulate the Director
to do my bidding, the way the German government wanted Lenin to do its bidding
to destabilize the Imperial Russian Government.] [I compared Lenin on his train ride
from Switzerland to Russia with me taking the train from Washington to Atlantic
City.]

There was a clear psychoanalytic link between my opening the session by offering my
therapist a copy of my ethics complaint and then making a seemingly incongruous
reference to Lenin. My therapist failed to inquire into this link and, indeed, broke
off any consideration of linkage by falling back on the literal observation, “You’re
not Lenin.”

Then I launched into two associations:

“I love a scene from the movie Hope and Glory. The movie is about the Blitz in
London in World War II. There’s a scene where a German pilot is shot down over
London. And a group of Londoners approach him in a residential neighborhood. The pilot is a mysterious stranger. They are curious about him, but he doesn’t seem menacing or dangerous or bad. He comes off as a kind of comic figure. [I compared the German pilot arriving in England with my arrival in Atlantic City and my sense of myself as a “mysterious stranger” in various historical contexts.]

“There’s a science fiction movie from the 1950s called *The Day The Earth Stood Still*. I always loved that movie. It’s about an extra-terrestrial alien who arrives on earth as a ‘mysterious stranger’ — but he is not a villain. The alien wants to promote peace on Earth. He urges humans to destroy their weapons and stop making war, which the alien fears humans will bring to distant planets. The alien fears that humans will ‘infect’ distant planets with violence and armed conflict.”

My therapist’s response to my ethics complaint was negative; she seemed more moralistic than analytical. She seemed to focus on paranoid-schizoid anxiety: that I saw my last therapist as a bad object because she had terminated my treatment with her, thus rupturing a valued relationship. Consequently, I wanted to annihilate that therapist.

But what about all the issues of introjective pathology that did not relate to the rupturing of a relationship (an anaclitic concern) but rather related to matters of conscience, guilt, self-esteem, and professional performance?

1– Ethics Complaint and Superego/Ego Ideal Issues and Social Adjustment/Idealization

How does paranoid-schizoid anxiety explain the fact that I *admire* people who themselves file ethics complaints? That is, I admire moral narcissists who possess high ideals?

(a) The Case of Jay D. Amsterdam, M.D.

I tend to be attracted to independent-minded people. Perhaps one such person from my past was Jay D. Amsterdam, M.D. I interacted with Dr. Amsterdam in 1978, when I was 24 years old. He was a 30-year-old psychiatry resident at the University of Pennsylvania School of Medicine who was conducting a drug study that I participated in. He struck me as independent-minded immediately at our first meeting. When I told him about my difficulties with my then treating psychiatrist, I. J. Oberman, D.O., he said, “That guy sounds like a prick — I’d advise you to stop seeing him.” Many psychiatrists would have stood up for their fellow doctor out of
professional loyalty. Then, years later, I discovered that in the year 2012, Amsterdam undertook the bold move of filing a 24-page ethics complaint against the chairman of Penn’s psychiatry department, where Amsterdam still worked. (Amsterdam’s complaint opened with the following quote: “The challenge of pursuing science in a morally justified way is one that every generation must take up.”). Amsterdam was the type of person with whom I felt a sense of twinship. And that sense of twinship, I believe, was based on the objective fact that he was independent-minded with a keen sense of moral values. He had a firm sense of right and wrong.

Therapist’s sleaziness and ethical challenges: At the first therapy session my therapist had me sign a contract giving her certain rights; I would have to make up missed sessions and if I didn’t make up the missed sessions she would bill me. A few weeks ago, when I talked about going on vacation my therapist told me I would have to make up the sessions I missed. I protested. She responded: “It’s in the document you signed.” I said, “I didn’t read that document.” Significantly, she admitted, “Nobody reads that document.” She takes financial advantage of patients knowing she has a duty to bring these contract terms to their attention because she is on notice that “nobody reads the document.” She just sits back in silence as patients naively sign away their rights. That’s sleazy and it’s exploitive. The therapist’s behavior is a notable ethical/professional lapse.

Social adjustment: I idealize the few people who resemble me: people with high ethical standards. I do not identify with ethically-challenged people. My idealization of people who resemble me appears to be a counterpart to my feelings of alienation around people who do not resemble me.

2~ The Therapist Failed to Look at the Relationship between my Ethics Complaint and my Internal Objects and History of Child Abuse

The psychoanalyst Leonard Shengold has written about George Orwell that the writer’s complex personality contained elements of both the authoritarian despot (Big Brother) and the fighter for justice and truth (the character Winston Smith). “George Orwell, the author bent on evolving a simple and honest prose, the fighter for truth and justice, or, more important, against lies and oppression. (We can speculate that his complex personality contained Big Brother and O’Brien as well as Winston Smith.) Chekhov wrote of having had to ‘squeeze the serf out of himself, drop by drop,’ and George Orwell must have made a similar effort; both men come through in their writing as truly moral and virtuous.” Orwell, according to Shengold, exhibited massive splitting and isolative defenses (a vertical split): a split between the observing ego and experiencing ego. “The strength and pervasiveness of his isolative
defenses do resemble what is found in those who have to ward off the overstimulation and rage that are the results of child abuse.” In Shengold’s opinion, Big Brother represents Orwell’s own strong sadistic trend, which he constantly fought against. “I feel that he used his strong will and persistent determination to force himself away from some hated and feared part of his nature probably these were primarily his sadistic and dominating impulses.”

Does my personality contain an inner despot against whom I fight with strong will and persistent determination? Is the ethics complaint I filed against my last therapist a derivative of this intrapsychic struggle that has its origin, in part, in a background of child abuse?

3. The Therapist Seems Oblivious to Psychic Determinism

I had previously provided my therapist a copy of a book I had written titled *Psychotherapy Reflections*. The book is a compilation of summaries of therapy sessions I had with my previous therapist. There is a passage in the book in which I assume the persona of an imaginary psychoanalyst who comments as follows on my narrative from the therapy session on August 21, 2018. The text refers to “extraterrestrial aliens” and “pathogens.” These two issues constituted a clustering of associations in that session that recurred at the present August 2 session. In the August 2 session I associated to the movie *The Day The Earth Stood Still*, which concerned extraterrestrial aliens and to Lenin, seen by Winston Churchill as a pathogen (plague bacillus). This clustering of associations is an example of psychic determinism. The therapist is oblivious to psychic determinism, ignores the context of associations, and, at this session, simply dismissed my initial reference to Lenin in factual terms, “You’re not Lenin.” Yes, I am not Lenin, but a seasoned analyst would ask herself why I incongruously referred to Lenin.

*August 21, 2018 session:* You know, sitting here listening to you, I couldn’t stop thinking about your extra-terrestrial metaphor from a few sessions back. You talked about the idea that you felt like an extra-terrestrial alien [Compare: The Day the Earth Stood Still]. That you had a different identity from everybody else – the humans. As if you had suddenly arrived on planet earth to the horror and amazement of the humans. You seem to be talking today about having those feelings in your family. As if you were an alien. You felt you had an alien identity.
That you were fundamentally different from everybody else. That you didn’t fit in. That you were treated like an outsider. Weren’t these also your feelings in the workplace: that somehow you were different from everybody else, that there was a

“lack of fit” between you and the people you worked with? I am reminded of a story by Kafka, The Metamorphosis. Have you read it? It’s about a man who is suddenly transformed into a giant insect – he is an alien in his family. Nabakov had the interesting idea that the story encapsulates the struggles of a creative person in a non-creative environment. Nabakov wrote that the central narrative theme he makes out in the story is the artist’s struggle for existence in a society replete with philistines that destroys him step by step. Perhaps you feel both alien and beyond the comprehension of others, but also superior to others, a person with special gifts. Many creative people struggle with these feelings. And, you know, I also sense possible envy and unconscious feelings of triumph in your report. I suspect that at some level you relished the idea of destroying your family’s “beautiful world” because it was denied to you. You know there is a psychological theory that the infant both loves and envies the mother’s breast: that at some level the infant wants to destroy the mother’s breast – precisely because it is good – at those moments the infant feels that the mother has withheld the breast from him. Your family’s beautiful world, their Paradise, as you called it, was denied to you and you envied it; you wanted to destroy it. I’d like to offer a reconstruction that ties together your creativity and your destructive impulses. It may be a regular feature of your mental life that when you envy something and cannot merge with it, you destroy it in fantasy, then recreate an image of that envied object in your mind. What I’m saying is that you envied your parent’s paradise, you could not have it, you proceeded to destroy it in fantasy, and you resurrected an image of it in your inner world. I suspect that we can find residues of former envied objects in your idealized world, your inner Garden of Eden, your own private paradise that you retreat to. But that’s only a possible reconstruction. Be that as it may. You once talked about your grandmother who in fact had an alien status in a legal sense in the United States. That she never adjusted to American society, American culture. And I wonder if there is an issue of intergenerational transmission here. That somehow you have adopted your grandmother’s sense of alienness. That that is your family heritage and your legacy. You assumed a kind of scapegoat identity as an outsider who has to live through the experience on a psychological level that your grandmother experienced in her adult life, as if to expiate your grandmother’s suffering. Perhaps a latent issue in your narrative is survivor guilt.

Then also, I am struck by the sense of contagion in your report. I have the sense that you see yourself as an invading virus, infecting a healthy person – and radically changing that person’s health status overnight, as it were. I remember your saying that your grandmother’s husband died in the great flu epidemic. How
he was probably a young man, that “suddenly, overnight” your mother’s family’s circumstances changed radically and unexpectedly with the death of her husband, the breadwinner. And you mentioned that you came down with scarlet fever as a young child, which seems tangentially related. Didn’t you say that you came down with scarlet fever at the exact age your mother was when her father died in 1918 – and that it was your mother who negligently fed you spoiled milk? I was thinking about your comment about the shift in the balance of power in your family when you were born. [Compare: Winston Churchill viewed Lenin as an invading pathogen.] In intergenerational terms I was thinking about your description of your mother’s family. With the death of your mother’s father in 1918, there was a remarkable power shift that must have occurred over time. You said that your mother’s older sister, over time, took on a maternal role or a caretaking role – you called it role reversal – in which more and more, your aunt (the child) took on the role of mother to your mother and her own mother. Your grandfather’s death was the source of your aunt’s power in the family – which must have been a mixed blessing for your aunt: loss of her father, burdensome responsibilities, but also a stepping stone to power. What I am saying is that with your birth there was a power shift in your family. And likewise, when your mother was growing up, there was a power shift in her family as well when her father died. These may be intergenerational issues. These are just some ideas, Mr. Freedman. We can return to these ideas at a later time if the material warrants. Any thoughts?

4- Therapist’s Use of Scapegoating — Suggestions of Anti-Semitism in the Therapist’s Work — Therapist’s Use of Me as a Container — Countertransference

My therapist said to me, “You did to your therapist what your employer did to you.” This statement is an example of the therapist confabulating facts to allow her to fit these “facts” into her internal schema of me as an aggressive (“violent”) bad object. The fact is that my employer lied about the reasons for my job termination and later filed an apparently perjured Response with a District agency alleging that it had determined that I was mentally unfit for employment and that I posed a direct threat in the workplace (the employer alleged that I was “potentially violent”). Perjury is a criminal act; it is a felony. The allegations I made in the ethics complaint against my last therapist were factual. In point of fact, I did not do to my therapist what my employer did to me. My employer lied about me but I did not lie about my previous therapist.

What is striking is that the dynamic that my therapist offered (“You did to your therapist what your employer did to you”) is classic anti-Semitism. One anti-Semitic stereotype is that Jews are hypocrites: “They complain about other people, but they act the same way.” See, Grunberger, B. “The Anti-Semite and the Oedipal Conflict.”
Grunberger writes: “The Jew represents the father, and from that perspective we can understand the various aspects of the anti-Semite’s behavior. We understand, for example, why the Jew excites so much attention, why his conduct must be perfect, and why his slightest moral weakness is exaggerated by the anti-Semite who would remain utterly indifferent, even approving or amused before the most shameful actions and moral turpitudes perpetrated by non-Jews. He reminds us of the adolescent at the climax of his Oedipus conflict, forgiving nothing in his parents and on the look-out for the slightest fault in their moral conduct, and particularly in respect to the father, as though he would say: ‘Look at yourself, you who preach morals to me and wish to criticize me at every moment.’” “The Anti-Semite and the Oedipal Conflict (emphasis added).”

The observation that “the Jew represents the father” might provide a window into my therapist’s countertransference. Is it possible that she sees me as her father? I wonder about my therapist’s repeated — and factually unsupported (see paragraph 5, below) — references to me committing “acts of violence” against others. Are the therapist’s factually distorted attributions to me related to the therapist’s own primal scene concerns: “Daddy, I know what you do to mommy in your bedroom. You commit acts of violence against mommy!”

5— Therapist Countertransference — Therapist’s Factually Distorted Allegation that my Ethics Complaint was an Act of Violence against my Previous Therapist

The therapist sometimes confabulates “facts” to allow her to fit those “facts” into her internal schema of me as a bad object who wantonly aggresses on others. Importantly, the therapist failed to consider the fact that it was someone in the ethics office at the National Association of Social Workers who recommended to me that I file a complaint in the first place. The ethics complaint wasn’t even my idea. The therapist’s repeated factual distortions aimed at preserving her negative projected image of me are troubling. Such behavior in a patient would be troubling; that kind of behavior in an analyst is doubly troubling.

An entry on my blog dated February 9, 2019 memorializes a conversation I had with an individual employed in the ethics office of the National Association of Social Workers:
So when I spoke with the guy at the NASW yesterday he said something interesting. I had said to him, “Say my therapist gives me referrals. I go to the other therapists she refers me to and they refuse to treat me, can I go back to my therapist for additional referrals? Does she have a duty in that case to provide additional referrals?”

He said, “that sounds like a gray area. Let me check.” He went off to talk to somebody who is knowledgeable. He came back and responded: “That’s a gray area. We have no protocol for that situation. But if that actually happens to you, I would recommend that you file a complaint against her with the state licensing Board. Now you have two options, you can file a complaint with the state licensing board or the NASW, but the problem is you don’t know if she’s a member of the NASW. I would advise you to file a complaint with the state licensing board.”

I found that interesting because I never mentioned filing a complaint. I was actually startled when I heard him say that. He raised the issue, not me.

At times, my therapist gives the impression that she lives in her own fantasy world of confabulated facts and boutique psychoanalytic theories.

6~ The Therapist’s Ego Functioning May Cause Her to Distort Aggressive Themes

Not infrequently the therapist uses hypercharged language to describe my relations with others, such as, “I see your behavior as an act of violence. Your behavior is violent.” She refers to my “attacks” on her and others. Is it possible that her depiction of me as highly aggressive is an artifact of her own ego’s inability to cope with aggressive themes?

Is it possible that therapist is a noncreative person who places a premium on socialization and affiliation (anaclitic development) but is lacking in strong internalized values (introjective development) that would prompt her to complain (like Dr. Amsterdam, see paragraph 1, above) about colleagues who committed ethical infractions?

The psychologist Donald MacKinnon gathered personality data on architects. The data clustered into three personality types: (I) the artist (creative), (II) neurotic (conflicted; artiste manqué), and (III) the average (adapted). (Architects were chosen because they combine art with science, business, even psychology). His research found significant differences among the three groups.
Group I [the highly creative group] scored highest, in MacKinnon’s analysis, on aggression (perhaps what my therapist calls “acts of violence,” “expelling,” and “attacks”), autonomy (independence), psychological complexity and richness, and ego strength (will); their goal was found to be “some inner artistic standard of excellence.”

Group II scored intermediate on independence, close to (I) on richness, and highest on anxiety; their goal was “efficient execution.”

Group III [the least creative group] scored highest on abasement, affiliation, and deference (socialization); their goal was to meet the standard of the group. (A therapist with this personality type would take a negative view of a highly-creative patient who filed an ethics complaint against a colleague; that therapist’s negative appraisal might be an artifact of the therapist’s level of ego strength relative to that of the highly-creative patient, namely, the therapist’s emphasis on collegial loyalty as opposed to a need to adhere to internalized values.)

We see distortions in the therapist’s appraisal of aggression in several areas of her work.

First, when I criticize my therapist’s work, she tells me that I am “attacking her” (invoking paranoid-schizoid anxiety). What about the possibility that my criticisms of her work have an altruistic motive based on therapeutic strivings; that I am trying to “cure” faults in her work? Harold Searles, M.D. wrote about patients who try to “cure” their analysts that is motivated by altruism. Searles, H. “The Patient as Therapist to his Analyst.” Searles wrote: “[T]here is an element of reality in all the patient’s distorted transference perceptions of the analyst, in keeping with Freud’s (1922) statement regarding projection that we do not project ‘into the blue, so to speak, where there is nothing of the sort already,’ but rather upon someone or something which offers us some reality bases of the projection. One of my papers (1972), concerning my work over nearly 20 years with an awesomely psychotic woman, had as its main theme the highlighting of the reality components (each of which had long remained unconscious to me) in her highly distorted, psychotic transference reactions to me.” And again: “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.” Note once again (see paragraph 2, above) how the therapist ignores the possible effects of child abuse in my personality; my ability to accurately appraise my therapist might be grounded in my experiences “with painfully unpredictable parents.” Searles speaks of the “integrity” required of the analyst to accept the reality basis of her patients’ intuitions about the analyst. By implication, the analyst who shows ethical compromises in her billing practices (see paragraph 1(b), above) might be the one most disposed, out of a lack of integrity, to pathologize her patient’s insights about her and allege that her patient is simply attacking her or “expelling” onto her. These integrity issues in an analyst might be related, and not simply discrete facts.

Second, my therapist overlooks the fact that creative patients tend to be “fault finders.” A creative patient’s criticism of his analyst is not necessarily an expression of paranoid schizoid anxiety.

“Torrance (1962) surveyed a large number of studies and compiled a list of eighty-four characteristics that aimed at differentiating highly creative persons from less creative ones. He listed them in alphabetic order from ‘accepts disorder’ to ‘withdrawn.’ Most of the characteristics seem desirable for any human being; for example, a highly creative person is described as altruistic, energetic, industrious, persistent, self-assertive, and versatile. But some entries on the list refer to diverging traits; for example, the person is attracted to the mysterious, defies conventions, is independent in judgment and thinking, has oddities of habit, is radical. Others at first impression seem negative: the person is discontented, disturbs organization, is a fault-finder, makes mistakes, is stubborn and temperamental, and so on.”

7~ Ethics Complaint as an Expression of Introjective Rather than Anaclitic Concerns; The Therapist’s Failure to Distinguish Between Behavior Rooted in Paranoid-Schizoid Anxiety and Behavior Rooted in Kleinian Superego Issues

At the August 2 session, the therapist repeatedly projected anaclitic concerns onto me in different contexts: “You filed a complaint against your last therapist because she terminated you (thereby rupturing a supportive relationship)”; “You are angry with your last employer because he fired you (thus rupturing a supportive
employment relationship); “Perhaps you feel anxiety about your vacation trip because all the people you once knew in Atlantic City are now dead.” These projections relate to the therapist’s anaclitic concerns. But what about my possible introjective concerns?

At this session, in assessing the ethics complaint I filed against my previous therapist, my therapist failed to distinguish between (1) an “attack” on an external object rooted in paranoid-schizoid anxiety (“your therapist terminated you, so you were angry with her”) and (2) an “attack” on an external object rooted in Klein’s conception of the superego “as the internal authority, [that] reflects on the self, makes judgments, exerts moral pressure, and is the seat of conscience, guilt and self-esteem.”

Superego, according to Klein, is an “internal structure or part of the self that, as the internal authority, reflects on the self, makes judgments, exerts moral pressure, and is the seat of conscience, guilt and self-esteem. In Kleinian thinking the superego is composed of a split-off part of the ego, into which is projected death instinct fused with life instinct, and good and bad aspects of the primary, and also later, objects.

It acquires both protective and threatening qualities. The superego and the ego share different aspects of the same objects; they develop in parallel through the process of introjection and projection. If all goes well, the internal objects in both ego and superego, which are initially extreme, become less so, and the two structures become increasingly reconciled.

In Klein’s view, the superego starts to form at the beginning of life rather than with the resolution of the Oedipus complex, as Freud theorized. The early superego is very severe but, in the process of development, becomes less severe and more realistic. In pathological development, the early severe superego does not become modified and, in extreme cases, the terrifying and idealized defused aspects of the primary objects are split off by the ego and banished into an area of deep unconscious. Klein came to think of these defused part-objects as separate from the superego, whereas others consider them as forming an abnormally destructive superego. Whether or not considered as superego, these extreme internal objects are thought by Klein and others to be associated with extreme disturbance and even psychosis. They are considered to be different from the ordinary early severe superego, which is based on predominantly fused instincts capable of modification.
Debate continues about the degree to which change can occur in the superego, about the exact nature of its constituent parts, and on the question of whether it is best conceptualized as a structure or as a function.” Reproduced from *The New Dictionary of Kleinian Thought* by Bott Spillius, E., Milton, J., Garvey, P., Couve, C. and Steiner, D. (Routledge, 2011).

Was my ethics complaint a response to my abandonment-related anxieties (an anaclitic concern) or was my ethics complaint a response to a superego, in Klein’s conceptualization, that has a special concern for moral behavior and professional ethics (an introjective concern)?

**July 29, 2019**

My therapist sees meaning in everything I say — and that meaning always relates to her in some way.

Last week, when I entered the office, I sat down and commented on the little items she had on a table: a paperweight, a book, other things. I said, “You re-arranged the items on the table.” She said, “That means you’re having anxiety about going on vacation and having to re-arrange your schedule with me.” I said, “Well, what I think I was doing was showing off. I wanted to show you how perceptive I am.”

Typically, she focuses on loss of a supportive relationship (as with going on vacation), while I focus on narcissism. She never gets to the narcissism. She is immersed in an anaclitic world while I am immersed in an introjective world.

I associate to a paper by Sidney Blatt:

The type of person described by Freud (1916) as “wrecked by success” is likely to have an introjective depression in which there is guilt over phallic strivings and symbolic oedipal triumphs. But success can also precipitate an anaclitic depression when the success involves the loss of a supportive relationship. The disturbances in both types of depression can be relatively mild or reach psychotic proportions. Hypomanic reactions can also occur in both types of depression; but in anaclitic depression this would consist of intense seeking and clinging to objects, **while in introjective depression there would be frantic attempts to demonstrate** strength, material accomplishments, power, physical attractiveness, **intellectual capacity**, or creativity as a way of seeking recognition and avoiding punishment and criticism. Compensatory
and restitutive hypomanic reactions in introjective depression do not require direct and physical contact with the object, but rather involve more symbolic derivatives such as recognition, approval, and material possessions.

I can’t deny the therapist’s interpretation. It may be true. But it is so shallow. If she had asked me: “Do you have anxiety about going on vacation, I would have said, “Yes.” The anxiety is not housed in a warded off part of my mind. I have clear access to it. So what is she revealing in her “interpretation?” She’s telling me what I knew in the first place. I have anxiety about going on vacation.

Where is this going? Is this really Kleinian analysis or a parody of Kleinian analysis?

July 25, 2019

I had a therapy session today. I spoke about my upcoming vacation from August 5 to August 9. She said, “You booked that vacation because of my vacation.” My therapist took a week off the last week of June. Some time prior she mentioned that she would be taking a vacation in late June. She is determined to foist on me the idea that I booked a vacation as a reaction to her.

FACT: I started to see my therapist in late February.

FACT: I had booked an Atlantic City vacation on January 8, but cancelled.

FACT: It’s true. I booked a second vacation after my therapist told me she would be taking off the last week in June.

I doubt that my second vacation had anything to do with her. And she says these things all the time, as if she is able to read my unconscious. Most of the time I can’t tell if she makes this crap up, or has genuine insight into my behavior. But in this instance relating to Atlantic City she obviously made that up. She thinks everything I do is a reaction to her. And that’s the precise reason Akin Gump fired me in 1991 and concluded that I was unemployable. I thought everything that happened was a reaction to me. See a problem? My therapist’s thinking is indistinguishable from that of a disturbed person.

Judge Judy always tells parties: “If I catch you in one lie, I won’t believe anything you tell me.”
I’ve had it with my therapist. Mark well: It was July 25, 2019 that I lost all confidence in my therapist.

*July 20, 2019*

My therapist often refers to the fact that I attack her. She sees this as “expelling” — an expression of paranoid-schizoid anxiety.

This morning it occurred to me that one could also interpret my attacks on her as an expression of depressive anxiety. I attack her in order to provoke her. I am seeking punishment. That’s moral masochism and guilt. Moral masochism and guilt in Klein’s theory is — depressive anxiety. Modell broadened the concept of survivor guilt to include more subtle forms of survival accompanied by unconscious guilt. For example, one of his patients was a talented woman who had married well and had achieved financial and professional success. She had risen far above the fate of her parents. The patient undid her success by experiencing it as unreal, only acting. She felt that “she was simply acting the part of a young matron culled from the pages of a women's magazine.” The patient provoked fights with her husband which eroded her marital happiness, and allowed herself little pleasure in any of her activities.

Feiner and Levenson described the ways in which a young adult's impulsive, destructive, provocative and self-destructive behavior can function, and is in fact unconsciously intended to function, as a means of protecting one or both parents. These young adults, part of a population of college dropouts studied intensively in a project of the William Alanson White Institute, sacrificed their own development in order to maintain a homeostatic family system, which protected their parents from facing their own individual and marital problems.

*July 19, 2019*

My therapist says (using her Klein/Bion terminology) that I have a tendency to expel, but not to take in.

What does Bion say about that?

I came across the following interesting observations:
The mother, thus, is a container for the infant’s contained, as described by Bion. The container-contained relationship in the mother-infant dyad of these patients appears to be rickety. Thus, the refusal to take in food can be viewed as a misguided defense against taking in the unbearable feelings projected by the parent. So, what about my therapist’s own projections — the “unbearable feelings projected by the therapist, the mother derivative?”

**July 13, 2019**

Little things about my therapist are starting to add up. Am I making a mountain out of a molehill or do I have a legitimate reason for concern? My therapist has a habit of taking my ordinary or non-malign comments or behaviors and using hypercharged, dramatic language to turn my comments into something that they are not.

I offer three examples:

I was talking about my friend Craig D. and she said, “He was evil.” (Evil?) I said, “He wasn’t evil. He had personality issues but he wasn’t evil.”

Last Thursday I was talking about my dentist from childhood, Marvin Sacks, DDS in totally benign terms. I mentioned that my mother used to take my sister and me to the dentist in late June at the end of the school year just before we went to Atlantic City. My therapist responded: “You thought your dentist was a sadist.” Where did she get that? I said, “That’s not true at all. I liked my dentist. I didn’t like dental pain, but I liked my dentist and I didn’t have any unusual fears about seeing him.” (My dentist was a friendly person who used to engage me in conversation in a soothing way.) What is striking is that I didn’t describe any negative feelings I had about the dentist or even state that he had ever performed any dental procedures on me. The notion that I had experienced any pain at the hands of this dentist was the therapist’s confabulation.

And you remember the interaction months ago when I was talking about Dr. P. and she said, “The things you wrote about Dr. P. on the Internet were an act of violence. You committed an act of violence against him.” (Violence?)

My question is whether she is nutty or is this Kleinian approach of hers just a lot of crap? (My therapist seems to make up interpretations. When I questioned whether her interpretations were simply her confabulations, she said, “It doesn’t matter. I am not aiming for factual accuracy.”)
I wonder. It really bothers me the way she distorts things. I don’t view her interpretations (or “interpretations”) as meaningful, useful or clarifying — simply disturbing and confusing.

Additional thoughts about my session on Thursday July 11, 2019. I talked about the emotional high I was on during the month of June. I talked about the summer solstice (June 21) and how every year, I experience an elation or euphoria about the month of June. I talked about the fact that Wagner’s opera Die Meistersinger takes place on June 24 — St. John’s Day and how the opera features a mentoring relationship between the older Hans Sachs, the poet-shoemaker, and the young Walther von Stolzing. I compared that relationship to my psychological relationship with Dr. P. and how I longed for a mentoring relationship with another male. I talked about how every year when I was a child I looked forward to going to Atlantic City in early July and how, just before we went to Atlantic City, my mother used to take my sister and me to the dentist. Then a light went off in my mind: “Hey, you know, I just thought of something. My dentist’s name was Sacks, Marvin Sacks, and I was just talking about Hans Sachs in Die Meistersinger.” Then I started talking about my thoughts about possible primal scene material.

Maybe I did view Dr. Sacks as a sadist — but not in the reality situation. I might have viewed Dr. Sacks as a sadist in the fantasy situation in which Dr. Sacks was symbolically my father sadistically inflicting pain on my mother during sex. I remember one year, my mother had to have a root canal and during the procedure my mother started to scream. Dr. Sacks made my mother scream. That’s a psychoanalytically rich statement that parallels an incident in the Third Act of Wagner’s Die Meistersinger. Hans Sachs has made a pair of shoes for Eva, a sexually-attractive young woman. Sachs has Eva try the shoes on. The shoes are too tight and Eva cries out. Commentators have pointed out the sexual symbolism of the shoes that are too tight and Eva’s crying out in pain. But that might be just a coincidence.

[Note how a Kleinian might distort this. A Kleinian might view the “sadistic dentist” as symbolic of the “bad object” or “bad mother” in a dyadic world made up of mother and infant. To a Freudian concerned with Oedipal issues the interaction is a three-party situation involving mother — sadistic father — self. Do you see the disturbing feelings you will arouse in a person with Oedipal conflicts whose conflicts
are seen as only two party issues? There’s something very disturbing to the patient about that distortion. Stanley Greenspan, M.D. talked about how vital it is that the analyst meet the patient at the patient’s specific stage of development. That’s precisely what’s not going on here.]

Are free associations really of limited value as my therapist seems to think? Are these associations really meaningless? How would another psychoanalyst view this material?

Is the following dream at all relevant? In the following dream write-up I describe primal scene material in association with thoughts about my childhood pediatrician. I also write about my perceived need for a mirror-image or alter ego relationship with my primary care doctor (Dr. P.) similar to the relationship between Freud and Fliess. The associations concern mentoring and a concern for achievement and admiration. Isn’t there significance in the fact that the cluster of associations in the following dream from September 2015 parallels in important ways my therapy report on July 11, 2019, discussed above. How can we dismiss clusters of associations in therapy that seem to repeat themselves in different sessions or contexts. Why are these (repeating) clusters of associations not meaningful to my therapist, a psychoanalyst?

**July 10, 2019**

**COMPARISON OF THERAPY SESSION ON JULY 9, 2019 AND AN EARLIER SESSION ON MAY 23,**

Thoughts About Psychotherapy Session on May 23, 2019

I have formed tentative thoughts about my therapist’s interaction with me at our session on Thursday, May 23, 2019.

General Impression:

The therapist appeared to have a significant level of anxiety that may have been triggered by a dream write-up I had given to her at the conclusion of the previous session on May 21. I speculate that my autonomy (in the form of my thinking, my individuality, and my rationality) sparked persecutory anxiety and envy in the therapist, which, in turn was discharged in her projective identification. I suspect that my failure to regress, like a majority of patients, in the therapeutic situation – that is, to develop a sense of collaboration with her – is a source of
anxiety for her. The therapist said that she felt “smothered” by my writings, that she perceived me as “high strung,” and that I tried to be my own analyst.

**QUESTION:** Does the therapist experience my depressive anxiety as a chronic stressor that continually threatens to arouse persecutory anxiety in her?

**SESSION July 2, 2019:** I told my therapist that I shipped a copy of my book *Psychotherapy Reflections* to a senior analyst at a local Psychoanalytic Training Institute. My therapist is acquainted with that senior analyst, and I suggested to my therapist that she contact the senior analyst to offer her an opportunity to comment on the book.

**JULY 4, 2019:** No session because of holiday.

**JULY 9, 2019:** I opened the session by telling the therapist that I no longer wanted to see her twice a week; that I preferred once-a-week sessions. My therapist was strongly displeased. I told her that I thought that she did not allow me to express myself, that the literature said that people with my personality problems (introjective pathology) have to be provided an opportunity for free association, and that I felt engulfed by her. My therapist said to me: “You find our work meaningless.” I said, “Yes.” My therapist said that I was “expelling” at this session (an apparent reference to what she perceived as my paranoid-schizoid anxiety); that I created “links” then destroyed them; and that my thinking was “ideographic” and not “symbolic.” She also referred expressly to Bion (and Freud).

I told my therapist about my association to what she was saying. “You remind me of the Communists. They come into a capitalist country and they use their ideology to label everything. For example, they see a man running his business and he’s no longer just a man running a business, he’s a “capitalist exploiter” — he “exploits labor.” Your work is so ideological. You are applying an ideology to me, that’s all. That’s all I see. I didn’t have the feeling Dr. Palombo was a Communist, that he was simply applying an ideology. He was more like an anthropologist. An anthropologist doesn’t have an agenda or ideology, well, maybe the ideology is just investigation and inquiry. That’s their agenda. The anthropologist is not concerned with applying labels from an ideology to a culture. The anthropologist is concerned with understanding another culture from the inside. When a culture has, for example, a certain religious ritual, the anthropologist tries to understand that ritual from the
perspective of people living in that culture. “What does it mean to them?” I thought Dr. Palombo’s work was like that. I see you as a Communist. I saw Dr. Palombo as an anthropologist.”

I made a mental note of something that struck me as important about my therapist’s behavior at the session. At three points in the session, my therapist seemed to emphasize her priority as a psychoanalyst, as if she were emphasizing her authority. I had the sense that, perhaps, at this session the therapist felt that her authority as an analyst had been questioned. Could these possible feelings in her have been aroused by some communication with an unknown third party? I have no way of knowing.

a.) At one point the therapist said, “I am the analyst.”

b.) At another point when I said, “I thought you would register my desire to see you once a week as an administrative issue,” she said, “I am a psychoanalyst — nothing is simply administrative to a psychoanalyst.” Note the phrase, “I am a psychoanalyst. . .”

c.) I found the therapist’s use of arcane jargon (ideographic, symbolic thought, links, and attacks on links) as a meretricious display of knowledge — as if she were emphasizing her prerogatives as a psychoanalyst.

Let us revisit the May 23, 2019 session: “3. It is noteworthy that the therapist reduced my self-analysis or dream analyses to a behavior (or possibly acting out): ‘You try to be your own analyst.’”

DISPLACEMENT:

a.) The statement (July 9, 2019) “You create links then destroy them” can be read as a paranoid displacement. It is possible that the therapist was thinking about my relationship with her, “You created a relationship with me and are now destroying that relationship.” The therapist’s seeming use of paranoid displacement would fit a pattern. In effect, the therapist displaced her anxieties about my abandoning her onto my “destructive acts” against a psychoanalytical construct, namely, “links.”

Let us revisit the session on May 23, 2019, namely my thoughts about the therapist’s seeming paranoid displacement: “2. The therapist’s statement that I was in fact smothering her and that she subjectively felt smothered by me was clearly persecutory. At the conclusion of the previous session, I asked: “Can I give you these materials?” The therapist
accepted the materials. She had free will; she could accept the materials or refuse to accept the materials. It was patently ridiculous for the therapist to claim that my giving her the materials was my act of smothering her in a situation where it was she herself who consented to accept the materials in the first place. The therapist’s statements about my smothering her were her persecutory fantasy. One wonders what it was about my writings that triggered her persecutory feelings. Why would an analyst apparently feel threatened by a patient’s written thoughts about a dream? It is noteworthy that at a previous session, the therapist appeared to show persecutory thinking in the session after I had given her one of my dream write-ups. I later wrote a letter about that session in which the therapist maintained that my primary care doctor had been afraid of me despite persuasive evidence I had given her that the doctor’s statements about his purported fears were false. I speculated in the letter I wrote about the session that the therapist might have displaced her persecutory fears about me onto my primary care doctor, so that it was no longer she who was afraid of me, it was the doctor who was afraid of me. I speculated that the therapist was showing a paranoid countertransference. That possible earlier paranoid countertransference (in the form of displacement) might parallel the therapist’s clearly persecutory statements at the current session that I was smothering her and that she felt smothered by me. In both cases, the apparent persecutory fears arose in the session after I had given her one of my dream write-ups.”

b.) My therapist is an analyst-in-training. In such a case perhaps we cannot rule out the operation of parallel process. Parallel process is a phenomenon noted between therapist and supervisor, whereby the therapist recreates, or parallels, the client’s problems by way of relating to the supervisor. The client’s transference and the therapist’s countertransference thus re-appear in the mirror of the therapist/supervisor relationship. What about the possibility that the therapist displaces her persecutory anxieties vis-a-vis her training analyst onto me, using me as a container for the anxieties aroused in the therapist/training analyst relationship. This merits attention because what I am suggesting is that I might be a scapegoat for the displaced feelings the therapist has vis-a-vis her training analyst. I have a lifelong history of scapegoating, first in my family and later in the workplace. Is there a mutual “dance” between me and my therapist in which psychologically I need to assume a scapegoat role even as my therapist needs to displace her persecutory anxiety onto me?

THE THERAPIST’S OWN DESTRUCTION OF LINKS:
a.) The therapist emphasized my act of “expelling” (i.e., projecting). She turned my negative therapeutic reaction to her into an involuntary confession: In her opinion it was *I* who impaired free association, it was *I* who fragmented everything, etc. When I said, “I feel that your work is one step away from bossiness—and I don’t like being bossed around” she replied: “I feel bossed around by you.” Arguably, the therapist’s interpretation can be seen as an attack on links. By attributing my negative therapeutic reaction to her to my act of “expelling,” she seemed to deny the transference meaning of that negative reaction. What about the possibility that I felt that my mother did not allow me to express myself, that I felt engulfed by my mother and bossed around by her. In attributing my negative therapeutic reaction to an act of “expelling,” as opposed to transference, the therapist denied a link between me and my mother or me and some other significant figure from childhood. Is it possible that at this session the therapist was destroying links and expelling (or projecting) that “attack on links” to me?

b.) The therapist appeared to interpret my “attack on links” as an intrapsychically-generated persecutory reaction to her. She seemed to deny the possibility that my tendency to attack links might be a sequel of trauma. It is well to keep in mind that I have a significant trauma history. In fact my MMPI two-point scale is 4/6, an indicator that an individual experienced in childhood a traumatic reaction to frightening displays of parental anger. Other MMPI scales validate abuse and scapegoating in my background.

Prof. C. Fred Alford has offered the following observations about Bion’s work on links: “To characterize these symptoms of trauma as attacks on linking stands in opposition to the way Bion (1967, pp. 101-102) sees attacks on linking: as an act of what Klein calls paranoid-schizoid rage at experience, designed to shatter the experience and perhaps to protect the vulnerable container. From the trauma perspective, attacks on linking are not the result of an internal rage at experience, but an external assault, penetration, or blow—that is, trauma.

This reflects an important way in which the trauma perspective on psychoanalysis changes the way we think about inner and outer. From a strictly psychoanalytic perspective, all the action is within: people create links, people destroy links, and so forth. While there is recognition of the role of another person as container while these links are being formed, a role almost always attributed to mother, there is little acknowledgement of the external forces that can shatter even a securely built
container (that is, self), and the links that have been made there. Instead, all the
action is internal; external events are secondary.

Freud turned away from the idea that the sexual abuse his women patients
remembered was real, and not fantasized (Freud letter to Fliess, quoted in Masson, p.
264). This was not a great moment in psychoanalysis. In a similar way, thinking
about attacks on linking as an external attack on the linking medium, the container,
caused by trauma, is not what Bion had in mind, but it seems to be the way trauma
works. Trauma rips open even the most well sealed container.”

In asserting that my attacks on links are intrapsychically-generated, the therapist is
denying the role of traumatic actors in my childhood. Once again, the therapist is
denying “links” between me and a negligent mother, an abusive father or other
aggressive and traumatogenic persons in my childhood. The denial of a patient’s
trauma can in itself be seen as an attack on the links between that patient and
traumatogenic persons in the patient’s developmental environment. Again, the
therapist’s statement to me “You destroy links” can be seen as her own act of
expelling (or projecting) — a symptom of her own persecutory anxiety in reaction to
me.

THE THERAPIST’S OWN ACTS OF EXPPELLING:

The therapist’s references to certain psychoanalytic jargon (links, ideographic,
symbolic thinking) were evidence of a close reading of Bion’s work. Bion refers to
attacks on links in his paper, “Attacks on Linking” (1959) and ideographic thinking
in “Differentiation of the Psychotic from the Non-Psychotic Personalities” (1957).

I find it peculiar and noteworthy that a patient could pinpoint specific technical
literature a therapist has read simply by listening carefully to the jargon the therapist
uses. I have a remote association. At autopsy, the presence of apple fragments in a
deceased’s stomach is evidence that the deceased consumed an apple in the recent
past. The apple had not yet been digested or “assimilated.” If the deceased had eaten
the apple a day earlier, there would be no trace of the apple in the stomach; the
digested or “assimilated” apple would have become a part of the deceased. Might we
say that a person in a training program, such as an analyst-in-training, is engaged in
the act of digesting or “assimilating” technical material and that in the trainee there
might be a tendency to “expel” jargon as if those phrases of jargon were fragments of
a recently consumed meal? Whereas in the experienced analyst, the analyst’s
technical knowledge has been metabolized and appears in the analyst’s work only as
“molecular traces” that guide the analyst’s interpretations but do not intrude in recognizable chunks.

My point is — is my therapist’s (inappropriate and confusing) use of psychoanalytic jargon evidence that she is struggling with the anxieties of being in a training role, which involves the “digestion” or assimilation of knowledge? Again, when the therapist states that I am expelling, is she not also expelling (or “vomiting”) her unassimilated fund of technical knowledge? Does the therapist’s act of “vomiting” on me point to unconscious feelings of nausea and disgust about working with me? One wonders.

What is the nature of the countertransference I am attributing to my therapist?

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General Impression:

The therapist appeared to have a significant level of anxiety that may have been triggered by a dream write-up I had given to her at the conclusion of the previous session on May 21. I speculate that my autonomy (in the form of my thinking, my individuality, and my rationality) sparked persecutory anxiety and envy in the therapist, which, in turn was discharged in her projective identification. I suspect that my failure to regress, like a majority of patients, in the therapeutic situation – that is, to develop a sense of collaboration with her – is a source of anxiety for her. The therapist said that she felt “smothered” by my writings, that she perceived me as “high strung,” and that I tried to be my own analyst.

QUESTION: Does the therapist experience my depressive anxiety as a chronic stressor that continually threatens to arouse persecutory anxiety in her?

1– Arguably, the therapist’s perception of me as one who was smothering her; as an individual who is high strung; and as a patient who tries to be his own analyst can be seen as her reaction to an intellectually-gifted patient. “It is the rare gifted child who is less than intense. Parents clearly view these children as challenging, exhausting,
high-strung, or high maintenance; these are not children characterized by being easy-going or happy just to go along with the decisions of a group. Many show intense curiosity about the world, often leading to a wide range of interests.” Gilman, B.J., “Academic Advocacy for Gifted Children: A Parent’s Complete Guide.”

Let us paraphrase: “It is the rare gifted psychotherapy patient who is less than intense. Therapists clearly view these patients as challenging, exhausting ("smothering"), high-strung, or high maintenance; these are not patients characterized by being easy-going or happy just to go along with a therapist’s feedback. Many show intense curiosity about the world and psychological matters.”

One wonders whether the therapist’s description of me as someone who tries to be his own analyst is related to the trait of autonomy. Autonomy, even pathological autonomy, is a characteristic of the gifted. “The need for autonomy developed early and remained an important part of [the gifted patient’s] personality. These exceptional young people wanted control over all aspects of their personal life.

They were frequently described as headstrong and oppositional. From the earliest years, they had an intense desire to do things on their own and in their own way, and they balked at interruptions or offers of help. One father recalled that his son was the only one in his grade-school class who refused to start his sentences at the margin. Grobman, J “Underachievement in Exceptionally Gifted Adolescents and Young Adults: A Psychiatrist’s View.” The therapist who has experience working with gifted patients will know how to work with the highly-autonomous, gifted patient.

One wonders whether the therapist’s description of me as “high strung,” “smothering,” and as an individual who tries to be his own analyst was a reaction to the dream write-up I had given to her at the conclusion of the previous session.

Grobman points out that “uncanny intuition” is a typical feature of intellectually-gifted patients. Grobman also speaks of the gifted individual’s need to “test intuitive insights” with “intellectual rigor.” Grobman, J., “A Psychodynamic Psychotherapy Approach to the Emotional Problems of Exceptionally and Profoundly Gifted Adolescents and Adults: A Psychiatrist’s Experience.” Is Grobman suggesting that it is not enough for some of these individuals to have intuitive insights about
themselves, but that they need to evaluate these insights against recognized psychological concepts? (I note that I had a perfect score on the Wisconsin Card Sorting Test, which indicates high concept formation ability.) Researchers have observed in some persons 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 such persons display cognitive giftedness in the area of self- and other-perceptiveness called “personal intelligence.” Park, L.C. and Imboden, T.J., et al. “Giftedness and Psychological Abuse in Borderline Personality Disorder: Their Relevance to Genesis and Treatment.” To what extent is intuitive giftedness, or “personal intelligence” a driver of self-analysis?

2- The therapist’s statement that I was in fact smothering her and that she subjectively felt smothered by me was clearly persecutory. At the conclusion of the previous session, I asked: “Can I give you these materials?” The therapist accepted the materials. She had free will; she could accept the materials or refuse to accept the materials. It was patently ridiculous for the therapist to claim that my giving her the materials was my act of smothering her in a situation where it was she herself who consented to accept the materials in the first place. The therapist’s statements about my smothering her were her persecutory fantasy. One wonders what it was about my writings that triggered her persecutory feelings. Why would an analyst apparently feel threatened by a patient’s written thoughts about a dream? It is noteworthy that at a previous session, the therapist appeared to show persecutory thinking in the session after I had given her one of my dream write-ups. I later wrote a letter about that session in which the therapist maintained that my primary care doctor had been afraid of me despite persuasive evidence I had given her that the doctor’s statements about his purported fears were false. I speculated in the letter I wrote about the session that the therapist might have displaced her persecutory fears about me onto my primary care doctor, so that it was no longer she who was afraid of me, it was the doctor who was afraid of me. I speculated that the therapist was showing a paranoid countertransference. That possible earlier paranoid countertransference (in the form of displacement) might parallel the therapist’s clearly persecutory statements at the current session that I was smothering her and that she felt smothered by me. In both cases, the apparent persecutory fears arose in the session after I had given her one of my dream write-ups.
3-- It is noteworthy that the therapist reduced my self-analysis or dream analyses to a behavior (or possibly acting out): “You try to be your own analyst.” An analyst should think about the analytic or psychodynamic implications of a patient’s behavior. At the first session I had told the therapist that I identified with Freud. I pointed out that, like Freud, I was the “child of my father’s old age” (my father was 47 when I was born) and that my father’s first name was Jacob. Kurt Eissler has pointed out that Freud might have had an identification with the biblical Joseph, famous as a dream interpreter:

“[O]ne may tentatively suggest that, given outstanding endowment, when the child’s identification is with a historical son-figure who was not burdened by guilt and ambivalence, and when that identification is based on reality factors rather than only on fantasy or like psychic elements–such a combination may be a propitious beginning for later eminence.” Eissler, K.R. Talent and Genius at 255 (New York: Quadrangle Books, 1971) (the biblical Joseph, the son of a Hebrew shepherd named Jacob, rose to prominence as Pharaoh’s dream interpreter. Joseph is described in the Bible as the son of his father’s old age). Eissler cautions, however, “[s]uch reality identification, if it is not combined with the sort of endowment that is necessary for its crystallization into achievement or success in reality, will, of course, lead to disturbances of a grave nature.” Id. at 254 n.

6-- The therapist appeared to have blocked out my earlier statements about my reality identification with Freud and failed to incorporate my statements into an evolving picture of a patient whose interest in psychoanalysis may have deep psychodynamic determinants.

At another session, I pointed out that the striking fact that I have a paternal cousin, a university professor, who wrote a book about Freud, and I speculated that my interest in Freud and psychoanalysis may be an issue of intergenerational transmission in my father’s family that is encoded in my unconscious. The therapist appeared to have blocked out my notable statements about my cousin, the Freud scholar, and failed to incorporate my statements into an evolving picture of a patient whose interest in psychoanalysis may have deep psychodynamic determinants.

It might also be useful to think about Didier Anzieu’s ideas about Freud’s preoccupation with psychoanalysis and the possible applicability of those ideas to my obsessive interest in analysis. Anzieu saw Freud’s theorization of psychoanalysis as a counterphobic defense against anxiety through intellectualization: permanently
ruminating on the instinctive, emotional world that was the actual object of fear. From a Kleinian viewpoint, Anzieu considered Freud’s “elaboration of psychoanalytic theory . . . corresponded to a setting up of obsessional defenses against depressive anxiety”—emphasizing Freud’s need to “defend himself against it through such a degree of intellectualization.” Can my interest in psychoanalysis be seen as a defense against depressive anxiety? What would be the implications of that? And why did my Kleinian therapist fail to consider how depressive anxiety might be a driver of my interest in analysis?

*I offer a “wild” or “stray” thought:* Is it possible that my (putative) depressive anxiety triggers or collaborates with the therapist’s occasional persecutory anxiety? I offer some thoughts, or rank speculation, based on the work of group theorist Elliott Jaques, who proposed that institutions are used by their individual members to reinforce mechanisms of defense against anxiety, and in particular against the recurrence of the early paranoid and depressive anxieties first described by Melanie Klein. Jaques, E. “On the Dynamics of Social Structure: A Contribution to the Psychoanalytical Study of Social Phenomena Deriving from the Views of Melanie Klein.”

Jaques describes the psychodynamics of the complex interplay that can prevail between a persecuting (paranoid) majority group and a minority group struggling with depressive anxiety. The following insights might offer clues about the dynamics between a therapist struggling at times with paranoid anxiety and a patient struggling at times with depressive anxiety.

Jaques writes: "Let us consider now certain aspects of the problem of the scapegoating of a minority group. As seen from the viewpoint of the community at large, the community is split into a good majority group and a bad minority—a split consistent with the splitting of internal objects into good and bad, and the creation of a good and bad internal world. The persecuting group's belief in its own good is preserved by heaping contempt upon and attacking the scapegoated group. The internal splitting mechanisms and preservation of the internal good objects of individuals, and the attack upon and contempt for internal bad persecutory objects, are reinforced by introjective identification of individuals with other members taking part in the group-sanctioned attack upon the scapegoat. If we now turn to the
minority groups, we may ask why only some minorities are selected for persecution while others are not. Here a feature often overlooked in consideration of minority problems may be of help. The members of the persecuted minority commonly entertain a precise and defined hatred and contempt for their persecutors which matches in intensity the contempt and aggression to which they themselves are subjected. That this should be so is perhaps not surprising. But in view of the selective factor in choice of persecuted minorities, must we not consider the possibility that one of the operative factors in this selection is the consensus in the minority group, at the phantasy level, to seek contempt and suffering. That is to say, there is an unconscious co-operation (or collusion) at the phantasy level between persecutor and persecuted. For the members of the minority group [or a patient struggling with depressive anxiety], such a collusion [with a therapist struggling at times with persecutory anxiety] carries its own gains—such as social justification for feelings of contempt and hatred for an external persecutor, with consequent alleviation of guilt and reinforcement of denial in the protection of internal good objects (emphasis added). Jaques at 428.

It is noteworthy that I served a scapegoat role in my family, and have been subjected to scapegoating in the workplace. “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 may be predisposed to become scapegoats in groups.” Hazell, C., Imaginary Groups.

Be that as it may.

My attempt to be “my own analyst” is not simply a behavior (or possibly acting out) but is the outgrowth of a cluster of identifiable personality traits related to creativity:

–I appear to have 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. It may be that I find the limitations of the two-person clinical setting as highly frustrating.

-I appear to have 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. It may be that I find the limitations of the two-person clinical setting as highly frustrating, particularly a clinical setting in which the therapist is unable to permit me to talk about the complexities I see and who seems to have a need to fragment my narrative into segments.

-I appear to have 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 (free association; note that my therapist impairs my free association by her incessant interventions). 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 (such as, for example, self-analysis). 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). It may be that I find the limitations of the two-person clinical setting as highly frustrating, particularly a clinical setting in which the therapist is unable to permit me to talk about the complexities I see and who seems to have a need to fragment my narrative into segments.
- I appear to have a desire for discovery, and a striving for general principles: aspects of creativity according to Taylor, which might be related to my written dream analyses.

- I appear to be independent in my cognitive abilities and value these abilities very much; it appears that I am able to hold many ideas in my mind at once. I will experience frustration in a clinical setting in which the therapist needs to fragment my cohesive formulations into segments.

5- Group theorists point out that in the cohesive group in which members have regressed to shared group identity, an autonomous individual who retains his thinking, his individuality, and his identity (that is, who fails to regress like other group members) will be the target of group aggression (i.e., scapegoating, cf. Jaques, above) and that the affect underlying the group’s attacks will be envy. Kernberg, O.F., Ideology, Conflict, and Leadership in Groups and Organizations. “Gradually it becomes evident that those who try to maintain a semblance of individuality [in the large group] 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.” Id.

QUESTION: Were my therapist’s obvious persecutory fears (“You are smothering me”) a negative counter-transference reaction triggered by my individuality (“You try to be your own analyst”), or my failure to regress like other patients, and that the affect underlying the therapist’s negative counter-transference was envy: envy of the thinking, individuality and rationality evidenced by my carefully worked-out dream write-ups and my failure to develop a sense of collectivity, or regress, in the therapeutic setting?

The session on May 23 seems to be the second time the therapist has had a persecutory reaction following my having given her one of my dream write-ups. There are concerns about an analyst who is unable to identify and work through her negative counter-transference, particularly after a patient had brought that possible counter-transference to her attention.

5- At one point in the session I related the following anecdote about a patient who was seeing Wilfred Bion in five-time per week analysis: The student spent the whole year on the couch, every weekday, elaborating his anxieties about his final exams,
which were 9 months away, his hopes, his fears and his endless ruminations about why he might not acquit himself well, and the consequences of this. After the exam, he continued to fill the sessions with his hopes and fears about how the exam had gone, and what the result might be, and so on, and so on. Bion remained silent during most of this, occasionally pointing out how these preoccupations served to rob the student of his analytic opportunities, and wondering about that. The day arrived when the results were published, and the student rushed into his session, straight to the couch, and exclaimed ‘I passed!’ ‘Passed what?’ asked Bion.

My reason for telling this anecdote? Early in my therapy I had told the therapist that I could profit from a less interactive approach. The therapist explained that she was a Kleinian and that Kleinians tend to be more interactive. At this session, I pointed out that Bion was, in fact, a Kleinian who was trained by Klein, yet he permitted his patient to engage in protracted solipsistic rumination.

The therapist proceeded to analyze Bion’s patient. She said that Bion’s patient’s solipsistic rumination was an attack on his analyst, Bion, but that Bion was able to serve as a container for the patient’s aggression.

I am reminded of Bion’s observation that the infant is unable to distinguish between the absent good mother and the present bad mother. Was the therapist expressing the view that when a patient engages in analytic reverie (ignoring the analyst) that the patient is aggressing on the analyst? Is the therapist saying that she views the patient’s need for analytic “space” as an attack on her? I find that troubling. Applying that viewpoint, a patient’s need for expansive elaboration runs the risk of appearing to the analyst as an aggressive act, and additionally can be used by the analyst to rationalize her own persecutory fears of being ignored by the patient.

Another wild thought: I was mildly troubled by the therapist's seemingly simplistic depiction of Bion and his patient. Was the therapist saying that because the patient was attacking Bion, that the patient was bad or that because Bion tolerated the attack for the year's treatment he was good (he was the good mother derivative, the patient nurturer)? Perhaps I am missing some fundamental psychoanalytical point the therapist was trying to get across, but the idea that springs to mind is that the therapist's formulation was simplistic: it has the appearance of a black and white (paranoid-schizoid) reality. For all we know, Bion might have been thinking: “This
patient is taxing my patience, but he's unusual and I can learn from this experience.” In that sense the patient was good. Also, perhaps the patient would have been better served seeing a Freudian analyst and Bion's patience with the patient only prolonged the patient's neurosis. In that sense, Bion would be bad. One wonders whether the therapist was unconsciously thinking about me (under the influence of persecutory anxiety): “This patient attacks me. He is bad” – rather than, “This patient is unusual, I can learn from this experience.” Perhaps we can see the therapist's unusual act of analyzing Bion's patient at the session as just another instance in which the therapist discharged her anxieties about me through the ego defense of displacement onto third parties. See paragraph 2, above.

July 9, 2019

I saw my therapist today. Her work is so jargon-laden that I strain to figure what she’s talking about. She told me that at this session I was “creating links then breaking them up.” She also told me that my thinking was more ideographic than symbolic. Then she started talking about Bion.

I struggle with things in my life. She doesn’t address the things I struggle with; she simply describes my interaction with her using jargon that I don’t understand. What do any of her observations about my “links” and my “ideographic thinking” have to do with my yearnings, my obsessions, my anxieties, and my strivings? I have no idea.

I told my therapist about my association to what she was saying. “You remind me of the Communists. They come into a capitalist country and they use their ideology to label everything. For example, they see a man running his business and he’s no longer just a man running a business, he’s a “capitalist exploiter” — he “exploits labor.” You’re work is so ideological. You are applying an ideology to me, that’s all. That’s all I see. I didn’t have the feeling Dr. Palombo was a Communist, that he was simply applying an ideology. He was more like an anthropologist. An anthropologist doesn’t have an agenda or ideology, well, maybe the ideology is just investigation and inquiry. That’s their agenda. The anthropologist is not concerned with applying labels from an ideology to a culture. The anthropologist is concerned with understanding another culture from the inside. When a culture has a certain religious ritual, the anthropologist tries to understand that ritual from the perspective of people living in that culture. “What does it mean to them?” I thought
Dr. Palombo’s work was like that. I see you as a Communist. I saw Dr. Palombo as an anthropologist.”

I seemed to lose her with those comments. I wonder if she was following me and my ideas. Or is this just more of my ideographic thinking?

**July 3, 2019**

I had a session with my therapist yesterday, a psychoanalyst. So, I was talking

— then my therapist went into one of her typical rambling discourses on what I had just said. I said to her, “How do I know you’re not making all that up? As far as I know all of that could be your confabulation.” She replied: “It doesn’t matter. I’m not looking for factual accuracy.” And I said: “When I was seeing Dr. Palombo, I had the sense that he would withhold an intervention until he was fairly certain of what he was saying.” And she said: “He probably did. But I don’t do that. I am not looking for accurate interpretations.”

Is this legitimate? What school of psychoanalysis is she following? I’m flabbergasted. I’m also thinking of terminating her. What’s the difference between seeing my therapist and seeing a tea leaf reader? It doesn’t matter?

**June 19, 2019**

**Thoughts about Psychoanalytic Narrative**

I discussed the issue of psychoanalytic narrative with my therapist at my session on June 18, 2019. I asked her if Kleinians are concerned with analytic narrative. She didn’t respond. I said, “I don’t understand how any analytic school that doesn’t attach importance to narrative can legitimately call itself analytic.”

I shared my thought that in analysis it’s as if the patient is telling two stories simultaneously. There are the particulars of what the patient is consciously aware of talking about – but when you look at the narrative as an independent text, an entirely different story can emerge. The analyst, in my opinion, needs to be sensitive to the unconsciously-determined subtext of the manifest content of the patient’s clinical report. In my opinion the analyst cannot see deep meaning in the patient’s
report unless she is sensitive to the underlying meaning of the particulars of the patient’s report as disclosed by a consideration of the context of the session as a whole.

I explained: “Have you ever heard of the Remote Associates Test? It’s a test of creativity. The test subject is given three words, and has to come up with a fourth word that relates to the three words he is given. For example, a person might be given the words ‘wrist,’ ‘dog,’ and ‘man.’ The correct response is ‘watch’—wristwatch, watchdog, and watchman. I said that an analytic narrative is like that. The patient is consciously aware of talking about particulars like a dog, a wrist, and a man— but lurking outside the patient’s consciousness is a cohesive text or narrative that confers a special meaning to the particulars of the patient’s clinical report. The patient is talking about the concept watch but doesn’t know it. That’s basically a metaphor that gives a flavor of analytic aims which focus on the particulars of the patient’s narrative, but also on the underlying story revealed upon looking at all the connections in the narrative. I asked the therapist—“how do Kleinians assess narrative if they are constantly interrupting the patient’s narrative flow?” She had no answer.

I think of another analogy, from chemistry. Imagine that the particulars of the patient’s report are chemical elements, like sodium and chlorine. The cohesive narrative (of which the patient is not aware) is the combination of these elements—the underling narrative is about something entirely different than the particulars, it is, in fact, a story about the compound table salt.

My therapist doesn’t think in these terms at all. I could tell from working with Dr. Palombo that he was intensely focused on these very concerns, namely, the two analytic stories, as it were, being told simultaneously by the patient. The conscious story made up of particulars, and the underlying cohesive narrative of which the patient is not consciously aware.

Another example is my book Significant Moments. Throughout the book there is a manifest text, but underlying the manifest text is a subtext that floats by imperceptibly. For example, in one section I talk about the philosopher, Nietzsche writing his book, All Too Human, a story that has no sexual meaning. But the subtext is about a boy having sex with his mother.

Continuing the metaphor, when I talk about “sodium,” my therapist will begin to talk about the psychological significance of “sodium.” If I then talk about “chlorine,”
she will stalk about the psychological meaning of “chlorine” for me. She has no sense that “chlorine” and “sodium,” *per se* are not the issue. The relevant unconscious issue for me, outside my conscious awareness and nowhere present in the manifest words of my clinical report, is the compound “table salt.” Analytic work requires an analyst who is a patient listener, someone who is psychologically able to listen to the patient with two ears and who is not preoccupied with her self-satisfying need to give “gifts” to the patient. What the analyst gives to the patient is less important in many ways than what the analyst can elicit from the patient with her interventions.

The therapist’s technique undermines the basic tenet of narrative analysis, namely, that the object of narrative analysis is the narrative itself (the “table salt”), as opposed to the events being narrated or the experiences or character of the narrator (that is, the “chlorine” and the “sodium”). The “sodium” and “chlorine” of a patient’s clinical report are simply building blocks of a narrative, not an end in themselves.

Hollway and Jefferson write: “There is a ‘gestalt’ informing each person’s life which it is the job of the analyst to elicit intact, and not destroy through following their own concerns about the particulars of a patient’s clinical report. There are similarities between the principle of respecting the narrator’s gestalt and the psychoanalytic method of free association. By asking the patient to say whatever comes to mind, the psychoanalyst is eliciting the kind of narrative that is not structured according to conscious logic, but according to unconscious logic; that is the associations follow pathways defined by emotional motivations, rather than rational intentions. According to psychoanalysis, unconscious dynamics are a product of attempts to avoid or master anxiety. Freud allowed the patient to ‘choose the subject of the day’s work’ in order that he could start out from whatever surface [the patient’s] unconscious happens to be presenting to his notice at the moment.’ By allowing the patient to set the agenda, ‘this was the method of truly free associations.’ Anxieties and attempts to defend against them, including the identity investments these give rise to, provide the key to a person’s gestalt. By eliciting a narrative structured according to the principles of free association, therefore, we secure access to a person’s concerns which would probably not be visible using a more traditional method. Hollway, W. and Jefferson, T., “Researching defended subjects with the free association narrative interviewing method.”

In a recent therapy session I opened with comments about the up-coming summer solstice. I was setting the agenda. The therapist immediately shifted the focus,
attempting to impose a relational meaning to my concerns (my personality is not relational; it is pathologically introjective, by the way). I generally recall her saying, “Perhaps you are talking about time and your feelings about the 50-minute limit on our sessions.” Did the therapist get that idea by looking at the context of the session (the “sodium” as well as the “chlorine”) or was she simply and haphazardly imposing her relational agenda to my ambiguous concerns that could have meant anything at all – or nothing at all, for that matter?

Hollway and Jefferson continue: The principle of gestalt is based on the idea that the whole is greater than the sum of parts. Wertheimer, the founder of gestalt psychology, objected to the way that, in his view, modern science proceeded from below to above. He believed that it was impossible to achieve an understanding of structured totals by starting with the ingredient parts which enter into them. On the contrary we shall need to understand the structure; we shall need to have insight into it. There is then some possibility that the components themselves will be understood (cited in Murphy and Kovach, 1972, p. 258-9).

This is the principle which we try to apply to our understanding of the ‘whole’ text. (For examples of the use of the gestalt principle in biographical-interpretative research, see Rosenthal, 1990 and 1993; Rosenthal and Bar-On, 1992; and Schutze, 1992.) Wertheimer’s primary law, that of ‘place in context’ (that significance was a function of the position in a wider framework), addressed exactly the problem of decontextualization of text which is inherent in the code and retrieve method. Wertheimer emphasized that ‘parts are defined by their relation to the system as a whole in which they are functioning’ (Murphy and Kovach, 1972, p. 258). Similarly the structuralist movement which started in social anthropology and linguistics emphasized that meanings could only be understood in relation to a larger whole, whether it be the culture, the sentence or the narrative.” Hollway, W. and Jefferson, T., “Researching defended subjects with the free association narrative interviewing method.”

May 26, 2019

Thoughts About Psychotherapy Session on May 23, 2019

I have formed tentative thoughts about my therapist’s interaction with me at our session on Thursday, May 23, 2019.
General Impression:

The therapist appeared to have a significant level of anxiety that may have been triggered by a dream write-up I had given to her at the conclusion of the previous session on May 21. I speculate that my autonomy (in the form of my thinking, my individuality, and my rationality) sparked persecutory anxiety and envy in the therapist, which, in turn was discharged in her projective identification. I suspect that my failure to regress, like a majority of patients, in the therapeutic situation – that is, to develop a sense of collaboration with her – is a source of anxiety for her. The therapist said that she felt “smothered” by my writings, that she perceived me as “high strung,” and that I tried to be my own analyst.

QUESTION: Does the therapist experience my depressive anxiety as a chronic stressor that continually threatens to arouse persecutory anxiety in her?

1 Arguably, the therapist’s perception of me as one who was smothering her; as an individual who is high strung; and as a patient who tries to be his own analyst can be seen as her reaction to an intellectually-gifted patient. “It is the rare gifted child who is less than intense. Parents clearly view these children as challenging, exhausting, high-strung, or high maintenance; these are not children characterized by being easy-going or happy just to go along with the decisions of a group. Many show intense curiosity about the world, often leading to a wide range of interests.” Gilman, B.J., “Academic Advocacy for Gifted Children: A Parent’s Complete Guide.”

Let us paraphrase: “It is the rare gifted psychotherapy patient who is less than intense. Therapists clearly view these patients as challenging, exhausting (“smothering”), high-strung, or high maintenance; these are not patients characterized by being easy-going or happy just to go along with a therapist’s feedback. Many show intense curiosity about the world and psychological matters.”

One wonders whether the therapist’s description of me as someone who tries to be his own analyst is related to the trait of autonomy. Autonomy, even pathological autonomy, is a characteristic of the gifted. “The need for autonomy developed early and remained an important part of [the gifted patient’s] personality. These exceptional young people wanted control over all aspects of their personal life. They were frequently described as headstrong and oppositional. From the earliest years, they had an intense desire to do things on their own and in their own way, and they balked at interruptions or offers of help. One father recalled that his son was the
only one in his grade-school class who refused to start his sentences at the margin. Grobman, J “Underachievement in Exceptionally Gifted Adolescents and Young Adults: A Psychiatrist’s View.” The therapist who has experience working with gifted patients will know how to work with the highly-autonomous, gifted patient.

One wonders whether the therapist’s description of me as “high strung,” “smothering,” and as an individual who tries to be his own analyst was a reaction to the dream write-up I had given to her at the conclusion of the previous session. Grobman points out that “uncanny intuition” is a typical feature of intellectually-gifted patients. Grobman also speaks of the gifted individual’s need to “test intuitive insights” with “intellectual rigor.” Grobman, J., “A Psychodynamic Psychotherapy Approach to the Emotional Problems of Exceptionally and Profoundly Gifted Adolescents and Adults: A Psychiatrist’s Experience.” Is Grobman suggesting that it is not enough for some of these individuals to have intuitive insights about themselves, but that they need to evaluate these insights against recognized psychological concepts? (I note that I had a perfect score on the Wisconsin Card Sorting Test, which indicates high concept formation ability.) Researchers have observed in some persons 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 such persons display cognitive giftedness in the area of self- and other-perceptiveness called “personal intelligence.” Park, L.C. and Imboden, T.J., et al. “Giftedness and Psychological Abuse in Borderline Personality Disorder: Their Relevance to Genesis and Treatment.” To what extent is intuitive giftedness, or “personal intelligence” a driver of self-analysis?

2- The therapist’s statement that I was in fact smothering her and that she subjectively felt smothered by me was clearly persecutory. At the conclusion of the previous session, I asked: “Can I give you these materials?” The therapist accepted the materials. She had free will; she could accept the materials or refuse to accept the materials. It was patently ridiculous for the therapist to claim that my giving her the materials was my act of smothering her in a situation where it was she herself who consented to accept the materials in the first place. The therapist’s statements about my smothering her were her persecutory fantasy. One wonders what it was about my writings that triggered her persecutory feelings. Why would an analyst apparently feel threatened by a patient’s written thoughts about a dream? It is noteworthy that at a
previous session, the therapist appeared to show persecutory thinking in the session after I had given her one of my dream write-ups. I later wrote a letter about that session in which the therapist maintained that my primary care doctor had been afraid of me despite persuasive evidence I had given her that the doctor’s statements about his purported fears were false. I speculated in the letter I wrote about the session that the therapist might have displaced her persecutory fears about me onto my primary care doctor, so that it was no longer she who was afraid of me, it was the doctor who was afraid of me. I speculated that the therapist was showing a paranoid countertransference. That possible earlier paranoid countertransference (in the form of displacement) might parallel the therapist’s clearly persecutory statements at the current session that I was smothering her and that she felt smothered by me. In both cases, the apparent persecutory fears arose in the session after I had given her one of my dream write-ups.

3- It is noteworthy that the therapist reduced my self-analysis or dream analyses to a behavior (or possibly acting out): “You try to be your own analyst.” An analyst should think about the analytic or psychodynamic implications of a patient’s behavior. At the first session I had told the therapist that I identified with Freud. I pointed out that, like Freud, I was the “child of my father’s old age” (my father was 47 when I was born) and that my father’s first name was Jacob. Kurt Eissler has pointed out that Freud might have had an identification with the biblical Joseph, famous as a dream interpreter:

“[O]ne may tentatively suggest that, given outstanding endowment, when the child’s identification is with a historical son-figure who was not burdened by guilt and ambivalence, and when that identification is based on reality factors rather than only on fantasy or like psychic elements–such a combination may be a propitious beginning for later eminence.” Eissler, K.R. Talent and Genius at 255 (New York: Quadrangle Books, 1971) (the biblical Joseph, the son of a Hebrew shepherd named Jacob, rose to prominence as Pharaoh’s dream interpreter. Joseph is described in the Bible as the son of his father’s old age). Eissler cautions, however, “[s]uch reality identification, if it is not combined with the sort of endowment that is necessary for its crystallization into achievement or success in reality, will, of course, lead to disturbances of a grave nature.” Id. at 254 n.
The therapist appeared to have blocked out my earlier statements about my reality identification with Freud and failed to incorporate my statements into an evolving picture of a patient whose interest in psychoanalysis may have deep psychodynamic determinants.

At another session, I pointed out that the striking fact that I have a paternal cousin, a university professor, who wrote a book about Freud, and I speculated that my interest in Freud and psychoanalysis may be an issue of intergenerational transmission in my father’s family that is encoded in my unconscious. The therapist appeared to have blocked out my notable statements about my cousin, the Freud scholar, and failed to incorporate my statements into an evolving picture of a patient whose interest in psychoanalysis may have deep psychodynamic determinants.

It might also be useful to think about Didier Anzieu’s ideas about Freud’s preoccupation with psychoanalysis and the possible applicability of those ideas to my obsessive interest in analysis. Anzieu saw Freud’s theorization of psychoanalysis as a counterphobic defense against anxiety through intellectualization: permanently ruminating on the instinctive, emotional world that was the actual object of fear. From a Kleinian viewpoint, Anzieu considered Freud’s “elaboration of psychoanalytic theory . . . corresponded to a setting up of obsessional defenses against depressive anxiety”—emphasizing Freud’s need to “defend himself against it through such a degree of intellectualization.” Can my interest in psychoanalysis be seen as a defense against depressive anxiety? What would be the implications of that? And why did my Kleinian therapist fail to consider how depressive anxiety might be a driver of my interest in analysis?

I offer a “wild” or “stray” thought: Is it possible that my (putative) depressive anxiety triggers or collaborates with the therapist’s occasional persecutory anxiety? I offer some thoughts, or rank speculation, based on the work of group theorist Elliott Jaques, who proposed that institutions are used by their individual members to reinforce mechanisms of defense against anxiety, and in particular against the recurrence of the early paranoid and depressive anxieties first described by Melanie Klein. Jaques, E. “On the Dynamics of Social Structure: A Contribution to the Psychoanalytical Study of Social Phenomena Deriving from the Views of Melanie Klein.”
Jaques describes the psychodynamics of the complex interplay that can prevail between a persecuting (paranoid) majority group and a minority group struggling with depressive anxiety. The following insights might offer clues about the dynamics between a therapist struggling at times with paranoid anxiety and a patient struggling at times with depressive anxiety.

Jaques writes: "Let us consider now certain aspects of the problem of the scapegoating of a minority group. As seen from the viewpoint of the community at large, the community is split into a good majority group and a bad minority—a split consistent with the splitting of internal objects into good and bad, and the creation of a good and bad internal world. The persecuting group's belief in its own good is preserved by heaping contempt upon and attacking the scapegoated group. The internal splitting mechanisms and preservation of the internal good objects of individuals, and the attack upon and contempt for internal bad persecutory objects, are reinforced by introjective identification of individuals with other members taking part in the group-sanctioned attack upon the scapegoat. If we now turn to the minority groups, we may ask why only some minorities are selected for persecution while others are not. Here a feature often overlooked in consideration of minority problems may be of help. The members of the persecuted minority commonly entertain a precise and defined hatred and contempt for their persecutors which matches in intensity the contempt and aggression to which they themselves are subjected. That this should be so is perhaps not surprising. But in view of the selective factor in choice of persecuted minorities, must we not consider the possibility that one of the operative factors in this selection is the consensus in the minority group, at the phantasy level, to seek contempt and suffering. That is to say, there is an unconscious co-operation (or collusion) at the phantasy level between persecutor and persecuted. For the members of the minority group [or a patient struggling with depressive anxiety], such a collusion [with a therapist struggling at times with persecutory anxiety] carries its own gains—such as social justification for feelings of contempt and hatred for an external persecutor, with consequent alleviation of guilt and reinforcement of denial in the protection of internal good objects (emphasis added). Jaques at 428.

It is noteworthy that I served a scapegoat role in my family, and have been subjected to scapegoating in the workplace. "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 may be predisposed to become scapegoats in groups.” Hazell, C., *Imaginary Groups.*

Be that as it may.

My attempt to be “my own analyst” is not simply a behavior (or possibly acting out) but is the outgrowth of a cluster of identifiable personality traits related to creativity:

–I appear to have 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. It may be that I find the limitations of the two-person clinical setting as highly frustrating.

–I appear to have 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. It may be that I find the limitations of the two-person clinical setting as highly frustrating, particularly a clinical setting in which the therapist is unable to permit me to talk about the complexities I see and who seems to have a need to fragment my narrative into segments.

–I appear to have 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 (free association; note that my therapist impairs my free association by her incessant interventions). 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 (such as, for example, self-analysis). 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). It may be that I find the limitations of the two-person clinical setting as highly frustrating, particularly a clinical setting in which the therapist is unable to permit me to talk about the complexities I see and who seems to have a need to fragment my narrative into segments.

–I appear to have a desire for discovery, and a striving for general principles: aspects of creativity according to Taylor, which might be related to my written dream analyses.

–I appear to be independent in my cognitive abilities and value these abilities very much; it appears that I am able to hold many ideas in my mind at once. I will experience frustration in a clinical setting in which the therapist needs to fragment my cohesive formulations into segments.

4– Group theorists point out that in the cohesive group in which members have regressed to shared group identity, an autonomous individual who retains his thinking, his individuality, and his identity (that is, who fails to regress like other group members) will be the target of group aggression (i.e., scapegoating, cf. Jaques, above) and that the affect underlying the group’s attacks will be envy. Kernberg, O.F., *Ideology, Conflict, and Leadership in Groups and Organizations*. “Gradually it becomes evident that those who try to maintain a semblance of individuality [in the large group] 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.” *Id.*
QUESTION: Were my therapist’s obvious persecutory fears (“You are smothering me”) a negative counter-transference reaction triggered by my individuality (“You try to be your own analyst”) , or my failure to regress like other patients, and that the affect underlying the therapist’s negative counter-transference was envy: envy of the thinking, individuality and rationality evidenced by my carefully worked-out dream write-ups and my failure to develop a sense of collectivity, or regress, in the therapeutic setting?

The session on May 23 seems to be the second time the therapist has had a persecutory reaction following my having given her one of my dream write-ups. There are concerns about an analyst who is unable to identify and work through her negative counter-transference, particularly after a patient had brought that possible counter-transference to her attention.

5-- At one point in the session I related the following anecdote about a patient who was seeing Wilfred Bion in five-time per week analysis: The student spent the whole year on the couch, every weekday, elaborating his anxieties about his final exams, which were 9 months away, his hopes, his fears and his endless ruminations about why he might not acquit himself well, and the consequences of this. After the exam, he continued to fill the sessions with his hopes and fears about how the exam had gone, and what the result might be, and so on, and so on. Bion remained silent during most of this, occasionally pointing out how these preoccupations served to rob the student of his analytic opportunities, and wondering about that. The day arrived when the results were published, and the student rushed into his session, straight to the couch, and exclaimed ‘I passed!’ ‘Passed what?’ asked Bion.

My reason for telling this anecdote? Early in my therapy I had told the therapist that I could profit from a less interactive approach. The therapist explained that she was a Kleinian and that Kleinians tend to be more interactive. At this session, I pointed out that Bion was, in fact, a Kleinian who was trained by Klein, yet he permitted his patient to engage in protracted solipsistic rumination.

The therapist proceeded to analyze Bion’s patient. She said that Bion’s patient’s solipsistic rumination was an attack on his analyst, Bion, but that Bion was able to serve as a container for the patient’s aggression.
I am reminded of Bion’s observation that the infant is unable to distinguish between the *absent good mother* and the *present bad mother*. Was the therapist expressing the view that when a patient engages in analytic reverie (ignoring the analyst) that the patient is aggressing on the analyst? Is the therapist saying that she views the patient’s need for analytic “space” as an attack on her? I find that troubling. Applying that viewpoint, a patient’s need for expansive elaboration runs the risk of appearing to the analyst as an aggressive act, and additionally can be used by the analyst to rationalize her own persecutory fears of being ignored by the patient.

*Another wild thought*: I was mildly troubled by the therapist’s seemingly simplistic depiction of Bion and his patient. Was the therapist saying that because the patient was attacking Bion, that the patient was *bad* or that because Bion tolerated the attack for the year’s treatment he was *good* (he was the good mother derivative, the patient nurturer)? Perhaps I am missing some fundamental psychoanalytical point the therapist was trying to get across, but the idea that springs to mind is that the therapist's formulation was simplistic: it has the appearance of a black and white (paranoid-schizoid) reality. For all we know, Bion might have been thinking: “This patient is taxing my patience, but he's unusual and I can learn from this experience.” In that sense the patient was *good*. Also, perhaps the patient would have been better served seeing a Freudian analyst and Bion's patience with the patient only prolonged the patient's neurosis. In that sense, Bion would be *bad*. One wonders whether the therapist was unconsciously thinking about me (under the influence of persecutory anxiety): “This patient attacks me. He is bad” – rather than, “This patient is unusual, I can learn from this experience.” Perhaps we can see the therapist's unusual act of analyzing Bion's patient at the session as just another instance in which the therapist discharged her anxieties about me through the ego defense of displacement onto third parties. See paragraph 2, above.