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FAMILY BACKGROUND

I grew up in a lower middle-class, conventional two-parent family with one six-years-older sister. There was considerable parental discord. My mother was of Polish-Catholic background and my father came from an Orthodox Jewish family. All family members showed high levels of narcissism. Neither I, nor any member of my family, has had a psychiatric admission. My sister's older daughter committed suicide when she was a senior in college; her younger daughter has struggled with depression and has been in treatment, including psychoanalysis.

RESULTS OF PSYCHOLOGICAL TESTING

Psychological testing I took in 2014 (MMPI and, Millon Inventory) yielded the diagnosis Personality Disorder Not Otherwise Specified, with prominent avoidant, schizoid, narcissistic and depressive traits. The results were consistent with a childhood background of abuse and scapegoating. Abuse and scapegoating in family of origin is evidenced by an MMPI Family Discord score of T=65. The MMPI social alienation score of T=71 supports an inference of scapegoating in the family of origin.

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

AVOIDANT TREND (MMPI T=76)

I have a dismissive avoidant attachment style and tend to view myself as emotionally independent, strong, and self-sufficient. I tend to be highly help rejecting, despite my recognition of a need for treatment and high levels of distress.

"Dismissive avoidant attachment occurs where the child's bids for proximity and support fail to achieve a positive interpersonal result (closeness, love, comfort), and instead typically result in a negative outcome (inattention, rejection, anger, disdain, abuse) for showing vulnerability or need. In such cases, reliance on an attachment figure, and involvement in a dependent or interdependent relationship more generally, is construed as frustrating, demeaning, and painful. Under these conditions, a person may decide, consciously or unconsciously, to rely on him- or herself—becoming what Bowlby called compulsively self reliant, and what others have called dismissive of attachment or simply avoidant (of intimacy, closeness, and interdependence). This stance can be conceptualized in terms of deactivation of the attachment system. Anything that would normally activate the system, such as physical or psychological threats to the self, feelings of vulnerability, or wishes for an attachment figure's protection or support, is defended against,

suppressed, countered with narcissistic self-enhancement, or denied." Babic, G., "Psychoanalysis and Theoretical Backgrounds in Attachment Theory Research."

According to Peter Fonagy, dismissive avoidant attachment style is the equivalent of introjective depression, or guilt-ridden depression. One psychologist writes: "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. Research suggests that such individuals may have histories of parental rejection and excessive authoritarian control early in life. 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." Kemmerer, D.D., "Anaclitic and Introjective Personality Distinctions among Psychotherapy Outpatients: Examining Clinical Change across Baseline and Therapy Phases."

SCHIZOID TREND (MMPI T=85)

I struggle with a sense of detachment and alienation. It's as if I view the world as a picture book and I am simply leafing through the pages. These feelings are both frustrating and gratifying, as if I were an actor watching a theatrical performance from the audience. That is, I would like to be on stage myself taking part in the production, but, at the same time, I am enthralled by the performance from my position in the audience. At times, I feel like an extra-terrestrial alien from another planet compelled to live my life among humans with whom I have little in common. I struggle with twin incompatible states: merger hunger and fear of engulfment.

NARCISSISTIC TREND (MMPI T=105)

A significant aspect of my narcissism is my need for affirmation in relation to a father figure, a need for male nurturance to fill the deficit left by disappointment in my father. I show a pattern of idealization, attempted merger, and disappointment in regard to significant male figures, which compulsively repeats the original traumatic disappointment in my father without healing the deficit. Specifically, my object hunger, idealizing merger needs, and longing for quasi-sacramental union with a male friend are fixations on archaic forms deriving from deficits in my frustrating relationship with a father unavailable for idealization. My need for an idealized relationship with a male friend is probably a screen for more deep-seated and fearful anxieties involving survival and dependency needs in relation to the mirroring maternal imago. While the attraction to male figures is evoked by deficits in relation to the idealized paternal imago, the intensity of the feelings involved suggests that they originate from a more primitive source less accessible to consciousness than disappointment in the father, that is, from the intensity of the grandiose merger I had and lost (with mother) rather than from the idealizing merger I had never had (with father). As Heinz Kohut interprets this kind of emotional situation, the son senses the mother's fear of the strong male figure with the adult penis and realizes (unconsciously) that her exaltation of him, the son, is maintained only so long as he does not develop into an independent male. Specifically, my adult dependency needs and my correlative fear of engulfment in merger, my need for mirroring by an ever changing roster of male figures are fixations on archaic forms deriving from deficits in my symbiotic relationship with my mother, who provided excessive mirroring at times and used me for her own selfobject needs, but who was unable to respond appropriately to my actual needs for separation-individuation and autonomy. Paraphrases of Cowan, J., "Blutbruderschaft and Self Psychology in D.H. Lawrence's Women in Love."

DEPRESSIVE TREND (MMPI T=76)

My depressive traits feature impaired ability to experience pleasure, particularly the pleasure of social relations. I also struggle with emotional numbing.

SCAPEGOATING IN FAMILY

Everett and Volgy have described the factors commonly found in dysfunctional families. In some dysfunctional families the most striking feature is that the mechanisms of splitting and projective identification are not displayed simply by an individual but pervade the parent-child subsystem. Splitting occurs when positive and negative feelings and thoughts are separated and experienced by family members in isolation of one another. This splitting distorts the family's perception of reality in such a way as to cause them to experience both internal or external events or issues as either "right" or "wrong," "black" or "white." Such rigidly split perceptions occur without regard to the complexity of situations, roles or relationships. Studies of dysfunctional families identified a similar pattern where within the family system "positive attributes of 'goodness' and negative attributes of 'badness' were separated and reinvested such that each family member appears

relatively preambivalent and single-minded in relation to the child." This splitting appears to protect the system from potential feelings of loss and disappointment as well as from the negative affects of anger and hostility.

The projective identification process within a system operates in concert with that of splitting to form rigid role assignments and expectations among specific family members (as in assigning the role of good child to one offspring and bad child to another). In the dysfunctional family, the threat of conflict or aggression in the marriage, which would also threaten the survival of the system, is projected onto a child who "owns" the projection and behaves more aggressively while returning the spousal subsystem to a calmer level. In assessing a clinical family, most family therapists would identify a central triangle, typically between parents and a child, which serves to balance the entire system.

The role of the triangulated child is often defined by either parentification (idealized child) or scapegoating. Everett and Volgy identified in the dysfunctional family predictable patterns of two central triangles and termed these coexisting triangles. It appears that the unique level of emotional intensity in the dysfunctional family requires multiple central triangles to balance and stabilize the system. They typically take the form of split and projected images of a triangulated "good" child [my sister] and "bad" child [me]. It appears that the tenuousness of the parental bonding and the continual threat of destructive anger requires two children to perform these specified roles in order to dissipate these threats and to ensure the survival of the system. "Borderline Disorders: Family Assessment and Treatment" in Chronic Disorders and the Family, Walsh, F and Anderson, C.M., eds. (1988).

SCAPEGOATING IN GROUPS

I have experienced severe scapegoating in two workplaces. In my last job, my supervisor told her employees she (delusionally) feared I might carry out a mass homicidal assault in the workplace. In an unrelated incident a coworker (who was later terminated for gross misconduct) told me: "We're all afraid of you. We're all afraid you are going to buy a gun, bring it in, and shoot everybody. Even the manager of your apartment building is afraid of you." My workplace problems were typical of a phenomenon known as "workplace mobbing," or emotional abuse in the workplace, such as "ganging up" by co-workers or superiors, to force someone out of the workplace through rumor, innuendo, intimidation, humiliation, discrediting, and isolation. Reference to group theory offers a possible explanation. Group theorist Wilfred Bion "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 be sucked into highly differentiated roles in the group such as leader or scapegoat. Those of us who fear extrusion more intensely may opt for less visible roles such as participant, voter, 'ordinary citizen,' etc." My anxieties, as an individualist, center on a fear of engulfment by the group and concomitant loss of identity while I do not have anxiety about being excluded by the group;

group-oriented people's anxieties center on losing connection with the group while they have no anxiety about adopting a group identity with loss of personal identity. My personality places me at high risk of scapegoating in groups since my anxieties about group membership are the polar opposite of those of group-oriented persons. Group members unconsciously pool their shared anxieties and defend against these anxieties in similar ways; my anxieties and defenses differ from those of the group, leaving me an outsider. My fear of engulfment in a group may relate back to my early fear of engulfment by my mother.

TRAUMA ISSUES

Schizotypal Trend (MMPI T=67) — ". . . physical neglect and emotional abuse were most strongly associated with schizotypal symptoms." Berenbaum, H., et al., "Psychological Trauma and Schizotypal Personality Disorder."

obsessive rumination

maladaptive daydreaming — Maladaptive daydreaming is a form of dissociating oneself from the real world, and getting absorbed into fantasies and mental imagery comprising vivid alternative universes, usually involving elaborate scenarios — that the individual prefers over reality. A history of childhood emotional abuse can be associated with daydreaming aimed to regulate emotional pain.

social withdrawal

anhedonia/social anhedonia — I have an impaired ability to experience pleasure in social activities.

betrayal trauma — Childhood physical or emotional abuse perpetrated by a family member may result in betrayal trauma where the child is not protected by mother.

MMPI 4/6 profile: The MMPI 4/6 profile is typical of individuals whose parental expectations or rules were enforced quite literally, without consideration or flexibility regarding the needs and distresses of the child. Parental (or other family members') tempers were apt to have been intensely threatening and frightening to the person as a small child. The parents were experienced as punitive and coercive of the child's will and indifferent to the child's distress, and punishments were often severe (e.g., Marks, Seeman, & Haller, 1974, p. 213, about half of their 46/64 adolescent sample reported having been beaten with a strap; they were described as defiant, disobedient, restless, and negativistic) . My father beat me with a strap when I was a small child.

dissociative depression — "Individuals with dissociative depression may have grown up in families which are "apparently normal" only; i.e., they are subtly dysfunctional despite lack of an overt history of adversity. Among the latter group, adult interpersonal attachment problems prevail which have their origin in early childhood. Such families are usually characterized by affect

dysregulation or narrow and rigid thinking styles which may also have traumatic origin. Dysfunctional communication styles of families (e.g., pseudomutuality, marital schism, double bind, high expressed emotion) are descriptive of dissociative patients' families." Sar, V., "Dissociative Depression is Resistant to Treatment-As-Usual."

inability to talk about feelings or identify emotions –"The results demonstrate a connection between emotional abuse and difficulty identifying emotions." Goldsmith, R.E. and Freyd, J.J., "Awareness for Emotional Abuse."

intergenerational trauma — Emotional loss, abuse and severe poverty in previous generations might have impacted my emotional development. Murray Bowen believed that a key implication of the multigenerational concept is that the roots of the most severe human problems, as well as of the highest levels of human adaptation, are generations deep. The multigenerational transmission process not only programs the levels of "self" people develop but also how people interact with others.

symptoms of emotional abuse — "Research revealed that experience of childhood emotional maltreatment contributed to impaired functioning in adulthood. If these experiences such as constant criticism, contempt, disapproval, rejection, put downs, and being ignored get internalized as a global and negative beliefs about oneself, their negative impact will be enduring in adulthood. Clinical observations revealed that individuals with traumatic events like emotional maltreatment in their childhood have more problems in relevant psychological tasks such as distress symptoms, interpersonal problems, and problems in experience of intimacy and forming mature relationship with authority figures in adulthood." Farazmand, S., "Mediating Role of Maladaptive Schemas between Childhood Emotional Maltreatment and Psychological Distress among College Students."

emotional numbing

entitled victimhood — A sense of entitlement can occur where the individual has the conscious sense that he was treated badly. See Kieffer, C., "Restitutive Selfobject Function in the 'Entitled Victim': A Relational Self-Psychological Perspective."

EDUCATION/COGNITIVE ISSUES

I have a law degree as well as a master of laws. I am licensed in Pennsylvania.

The Wechsler test yielded an overall IQ in the top 2% and a verbal IQ in the top 1%. percent.

I had a perfect score on the Wisconsin Card Sorting Test, indicating high executive functioning and concept formation ability.

My high psychoticism score on the MMPI combined with my high ego strength is consistent with high creative potential and a high capacity for original thinking. See Fodor, E.M., "Subclinical Manifestations of Psychosis-Proneness, Ego Strength, and Creativity" (psychosis-prone subjects who were high in ego strength exhibited the highest level of evaluated creativity in their proposed solutions to an engineering problem and also the highest scores on the remote associates test). My unusual thinking has caused some problems in my past psychotherapy.

PSYCHOTHERAPY

I have been in psychotherapy more or less continuously since 1992 with little benefit.

From 1992 to 1996 I saw two psychiatry residents at GW: Suzanne M. Pitts, M.D. (deceased) and Dimitrios Georgeopoulos, M.D. Their work was supportive. Both diagnosed me with psychotic mental illness (Bipolar Disorder and Paranoid Schizophrenia, respectively). I do not now nor have I ever had psychotic mental illness.

From 1996 to 2016 (20 years) I saw psychiatry residents at the DC Department of Behavioral Health (DHH) at 1 or 2-year intervals. Their work was supportive. In February 1996, attending psychiatrist Monika Acharya, M.D. (currently with GW) terminated my association with DBH. She said, "I am so sorry. You need psychodynamic therapy and our residents are trained in supportive psychotherapy." Dr. Acharya said that I needed to see a male therapist, that I could not work with a female. While I was at DBH a senior faculty member at St. Elizabeths (Albert H. Taub, M.D.) diagnosed me with paranoid schizophrenia. I do not now nor have I ever had paranoid schizophrenia.

From 2016-2017 I saw a social worker at the Psychiatric Institute of Washington. On occasion, he fell asleep during sessions. He was a 70-year-old man who liked to tell personal anecdotes. He was a professional sports announcer and we sometimes talked baseball.

From 2017-2018 I saw a social worker who did relational work that was not suited to my needs. From 2018-2019 I saw a social worker whose technique was time-limited. She terminated me after concluding that I was not making progress.

From 2019-2020 I saw a social worker whose work was object-oriented and who placed primary emphasis on my relationship with her. That work was not suitable for my needs.

I think I could benefit from psychoanalytically-oriented, exploratory psychodynamic work.

From January to December 1990 I was in therapy with a psychiatrist/psychoanalyst (Stanley R. Palombo, M.D.) (retired), an outstanding clinician who employed a classic psychoanalytic model. Dr. Palombo thought I could make significant progress with twice per week sessions, but unwisely I terminated. Dr. Palombo is the only clinician with whom I had a solid rapport.

Literature I have read indicates that exploratory, psychodynamic work that relies primarily on free association is optimal for individuals with introjective (guilt-ridden) depression. "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. Supportive psychotherapy, by contrast, was 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." "[A]naclitic patients do better in a treatment process that inhibits associational activity, whereas introjective patients do better in a treatment that facilitates it." Blatt, S.J and Shahar, G., "Psychoanalysis — With Whom, For What, And How? Comparisons with Psychotherapy."

In one study, "introjective (highly self-critical or perfectionistic) patients did particularly poorly in" in CBT and interpersonal therapy. Introjective patients "appear to be particularly responsive to classic [psychoanalysis] and to other long-term, psychodynamically oriented intensive treatments." See Blatt and Shahar at 426.

"Introjective patients . . . are more responsive to the interpretive aspects of the treatment process and the insights gained in treatment than to the relational aspects of the treatment process, and express their therapeutic progress primarily in changes in their manifest symptoms and cognitive functioning. The interpretive aspects are more congruent with the intellectualized cognitive style of introjective patients, who are initially more comfortable with an objective, detached, and task-oriented therapeutic relationship. More personal feelings about the therapist can provoke concerns about losing control and power, possibly even precipitating feelings of distrust and suspicion. Though introjective patients have the self-reflective capacities that would allow them to benefit from intensive therapy, the therapeutic process has to be more extended for them to begin to feel safe and secure with the therapist and to establish a meaningful therapeutic alliance based on feelings of trust and mutuality." See Blatt and Shahar at 429.