Personality Disorders, Attachment, and National Trauma: A Psychosociological Approach to Psychodynamic Therapy

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Take her, please, I say. Do you have any openings? But she is not mine to give away, and if she leaves me, if she says that perhaps she would be better with another therapist—for narcissistic patients are notoriously particular and there is always something wrong with the one who came before, to which you are the antidote, until you, too, are replaced—then it means I have failed. But to keep her on is also to fail.

The conundrum presented by this patient is a question that political psychology can answer in both a more expansive and a more contextualized way than individual psychotherapy. Revolutions, as Hannah Arendt wrote in *The Origins of Totalitarianism*, eat their own children. When the loyalty is absolute, the mirroring becomes too perfect. When the mirroring becomes too perfect, there is no area in which the individual or even the mass can operate.

All the air has been sucked out of the room. It is at this point that splitting must occur in order for the infant—or the populist mass—to survive. It mutates, it dissociates, it splits, it rejects the all-good leader for the all-bad one from which it has been trying to protect the all-good internalized partial object. Which is how Mike Pence nearly ended up on the scaffold—he inhabited the all-bad to Trump's attempt to continue the non-nuanced, unintegrated, all-good.

Introduction

The problem with a mirroring—any mirroring—that is too seamless is that it forecloses negotiated psychological space. It shuts down dialogue. How can I tell you I am hungry if you don't let me learn what hunger is so that I can communicate it to you? It is the overfed child. it is the child who cannot recognize its own hunger because its mother shuts that hunger down before it can manifest itself as an experience that the child is having that is separate from the mother's own experience and separate from the experience of the child as being experienced by the mother. Discomfort is how identity and independence develop. It is through discomfort that we come to know who we are.

However, the narcissist sees only perfect mirroring from the therapist. Anything that is imperfect is rushed past, skimmed over, which is ironic because that is precisely what the patient is here to discuss: life's imperfections. In the narcissist's wash of words, of endless petty complaints, of inconsolable whining, the patient says to me that if we have any issues between us at all, it is probably that we are just too similar. We are, in her mind, co-professionals.

The Nigerian author Chinua Achebe, in his novel *Things Fall Apart*, describes, in a chapter on the Igbo cosmology, the notion of the *chi*. *Chi* is the arbiter of our fate or destiny, with whom we forge a pre-natal contract that the individual makes with his or her destiny.

The subject of our inquiry is not her, but everyone and everything external to her. In this way, my patient shuts me down. I have no identity as the therapist. Yet she comes to me for help. Week after week, she implores me to explain to her why her chi is so unforgiving. How can I tell her that she has offended her *chi*. Am I her *chi*? I am beginning to wonder.

I am thinking about my borderline and narcissist patients and this contract that happens before we are even born, this contract we make with our *chi*. I had asked my colleague yesterday who she thought might be there to stand up for my own self-interest when negotiating with my *chi*? Obviously, the chi is practiced in this contract-making. What is the *chi's* story? Is it like the Tooth Fairy or Santa Claus? There for the many, or like a private fairy godmother, there for the one? Did the chi have someone else before we were together? And after I leave my earthly shrine, my body, do I return to the sun or to my chi?

Is this like the last act of McTeague—me and my *chi* chained together under the blazing noonday sun, my chi melting into the spot, doomed by the weight of my immobile corpse? What is the cosmology of caring in all this? If one's fate is indifferent, then why make a contract at all? I believe that we are each unique and that there is something ineffable that intersects with our context —social, historical, familial. The sum of which becomes our story. *Chi* speaks to this idea: "one mother gives birth; two chi create." We can look to Cain and Abel for precedent. This is a cosmology that is concerned with outcomes, not with ethics, not unlike psychotherapy.

In more classical Kleinian thought, we might speak of splitting—of the mother as an internalized representation of the all-good and all-bad breast. The nurturing vs. its antithesis. the dissociated parts that are born of mis-attunement or trauma have their own set of ORs that get activated under stress, under threat of annihilation. What is the down-regulated version of these object relations if healthy or can a healthier aspect of these internalized partial objects be engaged by self-understanding in the political identity realm?

Social theory, which *is* concerned with ethics, and psychoanalytic theory have long shared similar territory--although the full integration of the two has persistently been frustrated by the need to defend the very boundaries the intersection of these disciplines necessarily threatens. Is the field to be a psychoanalytically informed sociology or a socially contextualized psychoanalysis? I will suggest a synthesized working model of an integration that can be applied to borderline personality structure in the clinical process in such a way that sociological context can be an implicit element of the dialogical inquiry that is at the heart of therapeutic healing.

The etiology of borderline personality disorder (BPD), a condition that is marked by poor impulse control, emotional dysregulation, disorganization, self-harm, risky behavior, and a variety of interpersonal and relational problems, has roots in both trauma and attachment disorder. Recent research correlates the two so strongly that BPD is now being framed in the literature more narrowly as an attachment trauma.

The dangers these personality disorders pose for both individual and general social welfare can be lessened through an approach that assists individuals in gaining a sense of realistic self-efficacy in navigating their relationships in the larger social field.

Can psychotherapy prevent fascism? We can only answer that question by exploring the dynamics of fascism and group narcissism. What role does nostalgia play in this problematic dialogue in which those with vulnerable narcissism (I don't live up to my idealized self-states? intersect with pathological narcissism (I require you to mirror me because I have no self at all)? The major advances in our understanding of mental health tend to coincide with seismic shifts in the economic environment, with the collapse of empires or systems that seem fixed. These advances occur among a community of practitioners who exist in often quiet opposition to the prevailing order and yet require this very opposition to properly assess their environment and the pathologies that it creates. Like all utopian projects, this oppositional stance melds the what-is with the what-might-be. In other words, thesis-antithesis-synthesis.

So, what should our current economic crisis and the very real possibility that permanent affluence was illusory——that the boom-and-bust cycle is an unavoidable aspect of capitalism——be telling us about the next phase of development or even what the concept of a normative standard of emotional well-being should look like? What should a psychology that is not just reflective of our times but is proactive consist of? The client base of mental health is no longer to be found among an articulate middle class because the trappings that supported that class no longer exist.

To carefully tease out, as one of my training analysts once put it, "the tiniest tendrils of growth" involves the development of a therapist-client relationship——not a cost-effective prospect. In an age of managed care, fiscal crises, the relegation of the middle class to the status of the working poor, and over-medicated children, we may have the responsibility to devote ourselves to these tendrils, but do we have the luxury to do so? It seems hard to make an argument that such an investment is justifiable, let alone feasible. And as the world of verbal one-on-one interface loses ground to soundbites and texting, is "the talking cure" being dumbed down along with everything else? Skype and Facetime sessions are now available not only from therapists but from healers across a range of modalities. The intimacy that characterizes a therapeutic relationship——that is to say, the very thing that creates a space for healing——would seem to be lacking in such an arrangement. This is what we are facing on the micro level.

On the macro level, one may wonder why we aren't employing political psychology consultants? We have become the "smart" people in the way that jazz is the "smart" person's music—inevitably elitist or impenetrable. You don't fight a mob with a reasonable argument and a group of nuanced individuals. Is political psychology a taboo subject and if so, why the Right uses it all the time. Bannon has an institute devoted to it. But it is associated with the Left and carries with it the imprint of, specifically, the refugee Left of World War Two—i.e., Jews and communist sympathizers. T
hus the legacy of the Civil Rights battles of the 1960s, with its Hegelian roots that can be called out as radical by whoever chooses to weaponize such language.

Bannon's Academy for the Judeo-Christian West's "Gladiator School" is precisely that—using political psychology under the cloak of academic political studies, i.e., populism refined and made palatable for

“smart” people. When we really listen to individuals, we can influence the groups into which they subsume themselves. Information theory tells us—and studies have proven this true even in as polarized a nation as we are currently living in. Individuals who have subscribed to conspiracy theories and other weaponized social media can, if they are exposed for long enough to reliably-sourced news and information, have their minds changed. A 60-70% drop in beliefs in Trump’s election story was recently reported. It occurred when individuals were exposed to verifiable news sources consistently for a period of three weeks. The results are not lasting. As soon as the individuals were re-exposed to “fake news,” the seeming triumph of reason evaporated. These are individuals with no fully formed identity. They are pre-fed and do not know how to navigate the world of information on their own. They have no sense of subjectivity in which to house a sense of their own objectivity.

Mentalization-Based Treatment [define MBT] allows us to access our own mind as a mind in interaction with the mind of another. It is not assimilation, which requires the rejection of authentic identity with the replacement of a new one—even as a given individual might believe they virtue issue has embraced some truer more authentic version of the self that was stifled. When we map and diagram the object relations, the inter-relations, and the patterns and the patient recognize themselves in the visual, we’ve got our foot in the door. When they say yes to the structures that we’ve elaborated with them, they can see where else it exists in their lives and in the lives of those they associate with. It de-pathologizes them to themselves and defangs the power of the shame that is activated when they try to individuate from the all-good representation proffered by the dangerous seductions of authoritarianism. It is in this way that individual psychotherapy becomes a tool for political reasoning.

There is not much point in national analysis if the only people we are speaking to are other academics or theorists. Refugees like Fromm, Arendt, Canetti, Alice Miller and a list too long have codified the structures for us already. Fear activates attachment and creates binary, reductive emotional responses. Those who orchestrate populist mass movements know this and rely on it. The issue is how the Fascists of today utilize it and why the Left, which relies on nuance and the ability of the individual to make informed choices, shies away from applying these trued and true techniques.

We don’t know what Stone and Bannon really believe, but they are no dummies. The right instills and is free to create a frenzy of irrational choices, in which loyalty to the leader becomes the prime means of psychological survival. The Left sits around discussing philosophy and having internal disputes over shades of gray. The right shuts down the possibility of thought, while the left insists on thought as a virtue. Conversely, loyalty to the leader is the highest virtue of the totalitarian state.

If independent rational political thought in our current climate requires the ability to reflect and self-reflect, then the only way to combat mass populism is through the propagation of widely applicable models of the self in society. In other words, some sort of populist individual psychology is created. The 70s was notorious for having translated the models bequeathed by Europe’s refugees into “pop” models of psychological health that ultimately led to the “me” generation—and the almost sociopathic excesses of the 1980s.

Political psychology is currently for academics and politicians. it should be for right wing political extremists before they become extreme. I have spent years as a psychotherapist working with clients ‘in

the system.' A big part of what I do is psychoeducation. I demonstrate, unpack, and drill down deep into the psychodynamic structures that my patients have internalized, often across generations. that are making them project outward onto a blank screen in which there is absolute good and absolute evil, all good and all bad, and no nuance. To embrace nuance is tantamount to annihilation. as the late Mark Shields once said: "the Left falls in love and the Right falls in line."

I now teach psychodynamic and psychoanalytic theory in the prison system to incarcerated students who are completing their degrees. We go from the personal to the political, the individual to the nation, and in this way, they feel empowered and illuminated and in control of their own minds and emotions. One does not get swept away by political emotion if one has mastery over one's own mind and the sense of individuation that protects the individual from being swayed by the group.

Narcissism means that we are externally focused on one half of the mentalizing dialectic, the half in which are hyper-vigilant around how others see us but carries with it no sense of concern for how we see others. I teach psychoanalytic theory in the prison system, and I worked for a number of years in a methadone clinic that catered to the deep, semi-rural underclass of the area in which I live.

Narcissists—along with most other people—love hearing about themselves. As long as their interest can be held, as long as they are the center of focus, they are likely to pay attention to the one who is talking about them. Individual psychology—explaining the psychodynamics of the individuals experience, giving them a story on which to hang their identity—is enticing. Once we have them that way, we can reach them, we can expand on what they understand about themselves to get them to start thinking, really reflecting, on what they now know they might not know. Once you know something, you cannot unknow it.

Attachment, Self and Other, and Self-Regulation

The relational bond forged in infancy between the infant and the infant's primary attachment figure will determine such things as the brain development, emotional development, and psychological development of the infant. Numerous studies have pointed to the necessity of a "secure base" from which infants can progress from dependence to independence. When there are disruptions in attachment, either through prolonged separation, loss, or the primary caregiver's inability to respond optimally to the infant's needs, attachment disorders develop and can negatively impact both the individual and the social context in which the individual interacts across the lifespan.

Attachment is comprised of several components: the actual relationship developing in real time between caregiver and infant; the "object-relations" internalization of caregiver representations by the infant; and, as often as not, the internalized "legacy" representations of the caregiver's own "partial" or "incomplete" caregiver representations. This last component, although implied by theories going back to the dawn of psychoanalysis, has only recently been understood as a neurobiological and genetic aspect of inheritance. The development of the field of epigenetics has borne out what was long understood by psychoanalytic theorists in the wake of the Second World War.

When we are looking at an event or period that is not isolated (such as The Hunger Winter) but repetitive and pervasive throughout the historical experience of a given group or cultural subset of groups (African-Americans; Ashkenazi Jews) we are looking at a sensitivity that develops from repeated traumas that are similar but not identical. They are triggering the flight-or-fight mechanism, or whatever vulnerable the sensitivity to certain stimuli has created. The fact that the repeated trauma—the re-opening of the initial wound—occurs in a context in which the child desperately needs to maintain an attachment to the abusive parent, also means that the child must not know what he or she knows. This creates a sense of unreality and self-doubt, as this process of 'gaslighting' occurs.

Families that carry historical trauma include families whose history might include:

- slavery
- refugee/asylum seeker status
- immigration crises/deportees
- Holocaust survivors
- pogroms
- civil wars/occupation
- political violence
- famine
- religious/ethnic/racial persecution

These families often have a unique constellation of issues that overlap with, but are distinct from, families with non-historical intergenerational trauma. [an example of non-historical intergenerational trauma might include factors such as domestic violence, incest, sexual abuse, substance abuse or addiction, primary caregivers with mental illness, incarceration, or time spent in the foster system]. There is not a unifying narrative to which one owes allegiance. The root is different and the sense of identification is different. This form of trauma creates a vulnerability to certain mental health issues—but also creates resilience. The story of survival, whether overtly or covertly a part of the family narrative, becomes a part of the identity of the next generation and sets that individual apart. How is this different in a place like the US, where there is less national homogeneity than in many other countries? A shared national trauma—such as a civil war or occupation—is something that is known and understood by other members of the nation.

There are three ways that trauma is replicated and passed down the generations:

- Genetic Transmission
- Cultural Transmission
- Behavioral Transmission

Historical trauma utilizes all three pathways.

Disorganized attachment, in which the reassuring parent is also the parent who creates fear. The relational needs are activated by fear so that the fear-inducing parent becomes the parent that is called upon to soothe the infant/toddler/child from the fear-producing parent. This causes clinging and irrational

relational patterns throughout life. High reactivity is common. Second-order representations (the "self" as mirrored back to us by the reaction/response of the primary attachment figure) are the things that provide us with our internalized sense of self. Failures in this realm constitute an overwhelming majority of caregiver interactions. The "self" is mirrored back in the caregiver's experience rather than in the infant's experience. This produces an unstable identity. A sufficient number of accurately reflected interactions establishes an image of the internalized self that can be accessed on an as-needed basis when events and experiences are encountered that call upon the infant's "response identikit."

When an individual becomes depressed and fearful in response to abuser it actually activates the attachment system. The individual desires proximity to the caregiver (who is also the abuser). The seeking of proximity leads you back to the maltreatment. This leads, in some cases, to hyperactive or reactive attachment disorder (RAD). The "movement" to reaction in hypersensitive BPD is triggered whenever there is an emotional injury or a lapse in attunement or even a *perceived* lapse (i.e., the things that activate the fear that activates the proximity-seeking). This reactivity starts much earlier in BPD individuals than in the general population (hypersensitivity). BPD individuals go into infant-mode quicker than the general population. Attachment-system determines neurobiological link to hyper-arousal and rapid cycling.

Otto Kernberg discusses temperament, identity, and its behavioral manifestation is character. The patient becomes victim and persecutor at the same time, cycling role reversal. The patient learns that they have two dyadic systems. They begin to tolerate the awareness without having to keep them separate. The split is a protection of an ideal relation. If they don't protect it, they're afraid of being overwhelmed by the bad one. They start to become aware of the contradictory aspects of their sense of self. They are integrating incompatible emotional experiences.

With couples who have survived or are survivors of historical or political trauma, we see a survivor mentality emerge in their dyad. "Survivor mentality," at its most fundamental level, means loyalty to the story of suffering and survival. This loyalty utilizes shame, grief, loss, guilt, and anger. The story of survival becomes intertwined with expectations about achievement, obedience, success and failure. "Survivor mentality" robs many of us of all or part of our childhoods. Children raised in families with historical trauma feel the weight of responsibility for redressing the balance of loss and setting things right. One way we try—and fail—to accomplish this is to challenge the power of the perpetrator through reenactment, thus reinforcing the very victimization we are trying to overcome.

What is a Re-Enactment?

We've all seen Civil War or Revolutionary War re-enactors at play—or at work. Historical "re-enactors" often describe themselves as inhabiting two different eras: the one they were born into, and the one they connect to historically. Re-enactment means acting on unconscious impulses that will recreate the conditions of an old situation that remains unresolved. It is a replay of an old trauma in a new context—in the hopes of finally mastering it. For example, a child who was abused might seek out abusive relationships or might become an abuser to one's own children. The impulse may be very old, but the context in which that impulse is played out is a new one. Part of the problem involves trying to force the new paradigm to adapt to the old one.

Additionally, there are dangers associated with finally mastering the old trauma. The mastering exposes us to creates unmanageable anxiety. Why is this? Why would resolving old threats pose such a terrible risk to our sense of even very marginal safety? There are several reasons for this. They have their roots in the ways that we internalize our earliest caregivers, upon whom we depend for our very survival. In other words, resolving these conflicts can make us feel like we are risking annihilation. There is the threat of annihilating those to whom we are loyal, to those upon whom we have been completely dependent in the past. By reenacting the story time and time again and creating situations in which we are vulnerable to reenactment, we remain loyal to the story, to the master narrative of suffering.

Historical trauma creates a unique constellation of behavioral and emotional issues that are rooted in this idea of loyalty. It becomes the source of identity and the fabric of culture: I see this on a much smaller scale in my work with addicts and their families. There is a perverse cultural pride in remaining a part of the community of addicts, enforced beyond a mere psychological reading by addicts who come from families in which their parents and even grandparents were addicts. But historical trauma works differently. The trauma of the possibility of total physical annihilation mixes with the dangers off moral destruction or revenge through secular success. This threat of annihilation creates an internal split, a schizophrenic way of being, that adds to the splits already within Jewry. The disaster narrative that sets you apart from your peers also sets you apart from your era. You are not your own contemporary.

The genetic, cultural, and behavioral transmissions shift back and forth. They switch places throughout our uneasy encounter with the present. Part of us still lives in the *shtetl* or the ghetto or the internment camp or on the plantation. It is encoded in our DNA. When an entire nation has been traumatized, there is something that stands out in the families of those who have specific trauma that transcends the historic communal narrative A probable model for a narrative-emotional response loop in borderline patients might take the following route: The patient experiences something ("the story") and has to make a series of choices. These choices lead to the way that the story of that experience is represented to themselves narratively. This is the first step in being able to "speak" of it, categorize it, and file it away into the "portfolio" of the self. The historical identity and emotional memory have become a part of the master narrative of the self.

The task of initially processing the experience and assigning a category to it that is congruent with the rest of their historical identity also requires processing, containing and rejecting all of the other possible categories and interpretations. This necessitates a default, because the possibilities for conceiving of this narrative are limitless. Sorting through the other possible narratives is an overwhelming task for those with a borderline organization of the self. To compensate for this, the emotional response and its narrative result begin to develop a shortcut. Based on my work with addicted individuals, I believe that in borderline patients, this shortcut is stuck at a place of un-integration.

This "un-integration" might be part of the explanation for the tangential organization and labile affect that prevails when these patients try to relate a linear narrative experience. This also helps to explain the dramatically heightened awareness these patients have of the most minute shift in our own affective mirroring of patients' narratives. The patients' already-fractured identities are thus reinforced by their "reading' or "misreading" of therapist responses. It is for this reason that the therapist or counselor must maintain a steady, neutral affect, while simultaneously being empathic, warm and receptive. Too much or

too little affect will both be magnified by the patient's subjectivity. It also causes the patient to either fear engulfment and hence retreat from the dyad, or sense an abandonment that will activate a depressive, dependent position.

1.) How does this differ from/overlap with a mentalization model (MBT)?
2.) How does this differ from/overlap with a narrative therapy model?
3.) How does this differ from/overlap with a transference-focused model (TFP)?
4.) How does this differ from/overlap with a mind-map therapy (MMT)?

Would any of the above be explained by the outlines of Jewish historical narratives? Would any of the above explain the prevalence of borderline and bi-polar disorders and schizophrenia in Ashkenazi populations?

The structures of psychoanalytic inquiry themselves contain within them Jewish responses to modernity and also Jewish responses to intergenerational trauma that pre-dates the Holocaust by centuries. The question becomes: how does trauma inform the Jewish response to modernity? How does this in turn informed the structure of psychoanalysis? And how do these responses and metallization processes contribute to the degree of social and political compliance in the implementation of the Holocaust? The structures that determine the Jewish experience in modernity are the same structures that produced a reaction against the compliant responses. These questions and concerns reside, at the heart of any psychodynamic inquiry into a model of Jewish psychodynamics.

Attachment 101

The three forms of attachment most routinely recognized in the literature are secure, anxious/ambivalent, and avoidant (Baumrind, 1995). An additional attachment pattern, disorganized attachment, has been added to the list. Disorganized attachment, in which the reassuring parent is also the parent who is not reassuring, has been implied in a variety of psychological disorders including psychosis.

Environmental, biological, genetic and other factors carry weight in how attachment is formed. A direct correlation between a child's or young adult's schizophrenia, for example, and specific mistakes on the part of a parent was long ago abandoned. The concept of the "schizophrenogenic mother," first codified by Bruno Bettelheim, was catastrophic for millions of mothers devastated by their child's diagnosis of schizophrenia. In the Fifties and Sixties, the benighted mothers of those suffering with schizophrenia were filled with guilt and self-recrimination. We now know that schizophrenia and psychosis have far more complex and nuanced etiologies.

One way that an anxious/ambivalence attachment pattern is established is through a parental trauma pathway. This is in part due to the way that the relational needs of those who have experienced trauma are activated by fear. In such a model, the fear-inducing parent is also the parent who is called upon to soothe the infant/toddler/child from the fear-producing parent. This "schizoid" experience causes clinging and irrational relational patterns throughout life. Another component of this relational dyad is that the parent upon whom the child depends must be protected and retroactively rescued by the child from *that which has already happened*. The mourning that would elicit depression must be forever held at bay. We can continue to live in hope—but live in limbo, too—by refusing to integrate the all good and all bad aspects

of the parent into a unified, if disappointing, reality. This unrealized reality includes the possibility of repairing the original trauma by holding out for the triumph of the all good mothering figure,.

Parental behaviors that have their basis in specific traumas become the domain in which the child is looking for its whole parent. The child thus becomes the container for the split off parts of the parents. These parts are dangerous to the child but more importantly they are dangerous to the idealized all--good internal representation that the child must protect at all costs. If the child can take responsibility for the all –bad disowned parts of the parent's self, then at least the child can control these parts. The abuse visited upon the child by the parent now has some sort of logic attached to it. In this way, the child is able to create, within themselves, the boundaries that, in a healthy parent, create reasonable expectation on the part of the lived experience of the child. Better to know what is coming than to bear the misery of total randomness. This is the very early training that occurs in domestically violent families. A similar cycle is operative in children of parents with historical trauma.

High Reactivity

Second-order representations are the "self" as mirrored back to us by the reaction/response of the primary attachment figure. These representations aprovide us with our internalized sense of self. Failures in this realm constitute an overwhelming majority of caregiver interactions among those who develop BPD and the accompanying unstable or ruptured identities, i.e., the "self" that is mirrored back in the caregiver's experience rather than the infant's experience. Identity becomes unstable and malleable. Numerous maladaptive identities are generated in respond to external relationships. There are no valid bases for establishing an accurate view of these relationships. Conversely, a sufficient number of accurately reflected interactions establishes an image of the internalized self-with-other. This image of the internalized self can be accessed on an as-needed basis when events and experiences are encountered that call upon the infant's "response identikit"—as well as a secure internal representation of a soothing caregiver.

The individual becomes depressed and fearful in response to the abuser. As a result, the attachment system is actually activated. You desire proximity to the caregiver (who is also the abuser). The seeking of proximity leads you back to the maltreatment. This leads, in some cases, to hyperactive or reactive attachment disorder (RAD). The "movement" to reaction in hypersensitive BPD individuals occurs when there is an emotional injury or a lapse in attunement. The things that activate the fear will also activates the proximity-seeking. This cycle of hypersensitivity starts much earlier in BPD individuals than in the general population. Those with BPD regress far more quickly than non-BPD populations.

The attachment-system produces the neurobiological link to hyper-arousal and rapid cycling. The patient becomes victim and persecutor at the same time, cycling role reversal. The patient learns that they have two dyadic systems. They begin to tolerate the awareness without having to keep them separate. The split is a protection of an ideal relation. If they don't protect it, they're afraid of being overwhelmed by the bad one. They start to become aware of the contradictory aspects of their sense of self. They begin to integrate incompatible emotional experiences.

Narrative developmental self-reports of those individuals who develop BPD overwhelmingly correlate to an anxious/ambivalent style of attachment, although disorganized styles have also been implicated.

Baumrind identified parenting styles that run along an axis of involved and limit-setting (with the extreme being authoritarian) versus uninvolved and permissive (with the extreme being neglectful). Attachment theorist John Bowlby instead identified a parenting style that is a combination of two styles that force the child to continually shift between two extremes (Bowlby, 1988). Bowlby identifies this attachment style as absent/invasive.

Ideally, an environment of optimal frustration is present in which the all-good maternal introject can become sufficiently nuanced so that the child learns to carve out a space to develop autonomy that creates the self as a center of agency. Children reared in the absent/invasive context must contend with having no reasonable expectation of caregiver response whatsoever. Seemingly at random, and in response to a mysterious code only the caregiver seems to know, every need is anticipated before the child can even experience the need. It is a caregiving in which helplessness is not just fostered but is required in order for the child to have any chance of forging a connection to the primary caregiver. This also has the added implication of creating a sensibility in which the child must be hypervigilant in terms of the primary caregiver's needs. The child must effectively understand the attention he or she receives from the caregiver as a way of protecting the caregiver. This creates not only a justification for the bond with the caregiver but also a way of holding out the possibility of the caregiver eventually meeting the needs of the child in an appropriate way.

Conversely and without warning, this invasive caregiving is withdrawn as preemptively and randomly as it is given. The child is then left to cope on his or her own with no responsiveness on the part of the parent. The child's needs and the caregiver's needs thus become inseparable and the infant/primary caregiver merger is extended indefinitely. When we work with BPD patients, this analysis can inform the way that we understand the continual crises that require limitless rescue missions on our part. The request for rescue come fast and furious. It is why it is so essential when working with such patients that we set clear rules regarding place, time, phone calls and texts, adherence to schedules, and payment.

Another enormously important area to discuss with BPD patients concerns gift giving. A child who is reared in such an unpredictable and unboundaried context will forever be mystified and hypervigilant—poised between extremes of abandonment and engulfment. Looking for signs and cues as to what he or she might expect from others or might be expected to provide to others. Identity diffusion, in which boundaries between self and other are constantly blurred, thus becomes the prevailing experience of self. With this diffusion comes an added challenge: the child's identity becomes predicated upon external "mirrors," so that identity becomes a response rather than something wholly owned and belonging to the individual.

The production of given aspects of identity as a reaction to external demands, whether overt or covert, creates a struggle between dependence and devaluation. Neediness becomes a way of maintaining the connection to this idealized and undifferentiated introjected image of the parent. Crises are a way of bringing the parent back into play when the primary caregiver is too distant. Yet no sooner is the primary attachment figure present, than the fear of engulfment forces the child to push the caregiver away. It is a relentless cycle that borderline individuals carry with them into their adult relationships. This simultaneous defense against engulfment and abandonment necessitates binary modes of relational experience. The BPD individual cannot integrate the good and the bad of the primary caregiver, so every relationship is characterized in quick succession by idealization followed by devaluation—the devaluation

being the only way to disengage from the repeated failures of individuation that should have taken place at a developmentally-appropriate juncture.

The individual tries to integrate the good with the bad aspects of the internalized caregiver. This is the optimal condition where the child experience what Bruno Bettelheim (Bettelheim, 1987) describes as the "good-enough parent" who is supportive yet supplies optimal frustration. Faced instead with a binary choice between engulfment and abandonment, the child can't integrate the good and bad. It should be noted that earlier, from a much less forgiving perspective, Bettleheim posited the existence of the schizophrenogenic mother who would create the binary choice.. Under these conditions, risking being either engulfed or abandoned, the child loses the possibility of ever having the good-enough mother. Better to forever delay integration of good and bad in a single, ambiguously real individual than to lose the possibility of an integration which is always, tantalizingly, just out of arms' reach. This perennial threat of loss keeps the patient in a state of anticipatory mourning that is incomplete. The patient must always be in search of a new, potentially all-good object. The knowledge of the bad mother must be sealed off from the knowledge of the good mother. By knowing what we know we don't know, we split off and project the all-bad or persecutory object onto actors out in the world.

BPD patients protect the introjected all-good mother at the cost of their own individuation. As a result, these patients are never wholly adult nor wholly child. This split in their psyche is played out among their "treatment teams." These patients often bond instantly and with seeming irrevocability to one member of their caregiving team. They cast this team member in the role of savior, while casting other members in the role of the "bad cop." The savoir will, without sufficiently strong boundaries, be subjected to continual barrages of unscheduled contact and emergency situations. The patient's emotional lability can lead, ultimately, to caregiver burnout.

The savoir/villain dynamic will fluctuate over time. Roles will be re-assigned in what seem to be random and wholly unexpected fashion. This mirrors the arbitrariness of early caregiver interactions and the internal split of the all-good and all-bad primary attachment figure. Such patients will often maintain diametrically opposed narratives of their treatment, once again mirroring their internal split representations of caregivers. They tend to create chaos in inter- and intra-agency settings where coordination of care is required. They also create intense counter-transference issues in the individuals who work with them therapeutically. Therapists struggle with the sense of unreality that is projected onto them by borderline patients, as well as the resultant emotional ambivalence that emerges in the transference.

Transference may create a feeling of discomfort as the therapist is idealized and overvalued. The sense of being unable to live up to the patient's idealized version of the therapist can result in powerful feelings on the part of the therapist. These feelings range from embarrassment, guilt and shame to a sense of outright hostility or feelings of disparagement toward the patient. The therapist must alternatively inhabit idealized all good and devalued all bad projective identifications. In this way, these patients impede and overwhelm the very people upon whom they often depend for their most basic needs. The internal split is thus reinforced and the projection of this internalized world onto the outer world to which they go for help becomes exactly what they believed it would be. There is vindication of their worst beliefs about themselves and the world. The failures of the people meant to protect them are abundantly manifest..

The “Paranoid-Schizoid” Position, Integration, and the “Depressive” Position

In classical Kleinian theory, the process of integrating the all-good and all-bad internalized split objects results in a sense of almost unbearable loss. *The New Dictionary of Kleinian Thought* (Routledge, 2011) describes the process that occurs as the individual lowers the staunch, binary protection “on behalf of the [all good] object” as an experience of “remorseful guilt” and “poignant sadness.” This acute sadness is a by-product of the maturation process, in which our caregivers become real, integrated individuals with concomitant realistic limitations. We must dispense with the fantasy of a rescuing and omniscient object, and thus dispense with our own sense of [infantile] omnipotence, as well. A sense of being disloyal to or of betraying the idealized object is another, though less often discussed, aspect of this integration. Maturation thus involves sadness and anger.

A sense of abandonment by the idealized all-good object works in tandem with the sense of having abandoned the all-good idealized object. This explains the fierce loyalty in terms of defending and protecting abusive parents that many who work in the social service sector observe in their young patients. This same binary defensiveness accompanies projections onto idealized political figures and explains the way that demagoguery can take root among large parts of the polity by eliciting the most primitive and undifferentiated aspects of the individual. The internalized split finds a holding environment—and an externalized validation of the fantasy of omnipotence—among fellow “true believers.” In this way, the paranoid-schizoid position in the individual transfers to a national level. The process of assimilation in historically marginalized ethnic, racial, gendered, and religious groups is another place where this split is evident. It tends to manifest in the many anxious and ambivalent aspects of what W.E.B. DuBois termed “double consciousness.” The anxiety that is experienced by individuals experiencing delayed integration is actually anxiety *for the internalized object*, which is now, paradoxically, in danger from the very individual who is experiencing the anxiety.

Rupture and Repair

As individuals work through the maturation process, they begin to find ways to reconnect with the loved-and-hated object through what is understood as a cycle of rupture and repair. The “object” will do something that elicits the dominance of the hated, all-bad object. Usually, these are small things involving a failure to respond adequately to a demand or desire or need.

These failures are imperative for mother-infant individuation, as they help to establish a state of “optimal frustration,” in which the infant can gradually establish its own capacities for self-soothing. There failures can also serve as the tentative beginnings of self/other differentiation that will lead to an integrated, imperfect internalized object representation later on. The cycles of rupture and repair actually strengthen, rather than diminish the relational bond. However, the cycles are strengthening the bonds only if the attachment pattern has been relatively secure and reasonable, realistic expectations of caregiver response have been established.

The Mind of Another

The ability to infer the mental states of others develops within an affective attachment context. Failures in this early developmental realm result in much of the behavior of BPD-disordered patients. The

mystification in which they experienced early attachment leads to a distrust of others' motives. It also leads to the BPD's inability to "read" behavior accurately and make sound judgements about what other people are thinking, feeling, or intending.

This has been detailed in depth by Anthony Bateman and Peter Fonagy in their work at the Anna Freud Centre in London and has led to the development of mentalization-based treatment of MBT—though it should be noted that Bateman and Fonagy locate the attachment disorder in a disorganized rather than anxious/ambivalent attachment pattern. The disorganized attachment pattern, less binary and more chaotic than the anxious/ambivalent pattern, is a more recent addition to the classic patterns and can be understood as an extension of the "mystification" that takes place in the absent/invasive scheme. It is this same mystification that impacts the sense of reality of those who are working with these individuals.

Awakening the Rescuer

The risks of working with BPD for the therapist are many and varied. The natural propensity of those in the helping professions to slip into rescuer mode is especially heightened when working with BPD individuals. Boundary-setting is imperative. The great Kleinian analyst Otto Kernberg, for example, sets boundaries through establishing contracts with these clients, so that when the contracts are violated, the therapist has a neutral place from which to operate. The split in the rescuer is aroused, and the ability to tolerate being disliked or hated is severely tested.

My experiences working as a psychoanalytically trained clinician at a methadone clinic threw into bold relief the absence in my awareness of the social stratification inherent in the mental health system. Trained to practice analytically-informed talk therapy with educated clients, I was suddenly confronted with patients—this was a medical facility—on an almost industrial scale. I certainly hard to operate in an industrial model: top-down authority; 30-minute sessions; screening tools and paperwork; crisis management; case management; and coordination of care that was not just medical and social, but legal in nature, as well.

Additionally, I was cast in the role of gatekeeper to the methadone, which created an intense power differential with these patients—whose very problems stemmed, in large part, from institutionalized power differentials, often several generations in the making. This left very little time to connect with my patients in a way that would be truly generative and healing. It was triage. Like many who do "agency" work, I found myself saving the "mundane" parts of the job for post-session time. That meant that I was connecting to my patients but having to stay hours afterwards in order to catch up on paperwork. In my own way, I became "addicted" to the high-stakes intensity of working with such a desperate and imperiled population of patients.

Coming as I do from an intensively self-psychological and attachment-oriented background, I have learned that the theoretical framework in which I was trained for a full decade has very much become who I am as a practitioner. What you "do" in terms of actively working patients can start to become invisible to you. After a certain number of years in this profession, you begin, as Kohutian psychoanalyst Louisa Livingston once said in a training analysis, to "recognize this stuff" (Livingstone, 2006). "This stuff" refers to patterns of dysfunction, probable behaviors that can be extrapolated from these patterns.

The stuff also refers to the probable familial structures from which these patterns emerged and continue to persist into adulthood. It refers to the likely emotional responses to the behaviors and interactions generated by these dysfunctional patterns that perpetuate the cycle. All of this stuff constitutes the "presenting problem." Like forensic reconstruction, there are a limited number of factors on each spectrum that will lead to a limited number of intersections in global spheres of functioning. Any psychoanalytic or psychodynamic theory will engage with an array of these possible intersections.

What is constant among theories is that they engage with the human experience. What is variable among theories is the vocabulary used to conceptualize theoretical constructs within the context of different approaches to treatment. The prioritization of what is understood to be problematic from the subjectivity of any given theory also varies. Even subjectivity itself, as a "stance," is only one among several theoretical orientations regarding client subjectivity, therapist subjectivity, or a goal of objectivity within the therapeutic alliance.

Analytic institutes remain infamous for internecine conflict and fractiousness a full century past Freud's paternalistic authoritarianism. Internal rifts and feuds occur, often around the tiniest gradations in terms of concepts or terminology or even the naming of systems and theory. I myself completed my training at an institute that had broken with another institute within the same theoretical school. Initially, it was a geographical rift that translated into a *prima facie* theoretical rift: Chicago (where Kohut was located) vs. New York (where some of his former disciples were located). Analytic distinctions were drawn between the cultural and demographic "field" in these respective cities.

Later, the institute in New York at which I had trained broke in two over whether to include a single word. The Training and Research Institute for Self Psychology is no longer on speaking terms with The Training and Research Institute for Relational Self Psychology. They vie with each other for title to Kohut's legacy. We need to remember that when we are talking about theories of counseling, we are, at the same time, talking about professional identity. We are asking about a given practitioner's theoretical family-of-origin. We are also asking about the practitioner's ability to individuate and forge a new, cohesive identity that may incorporate influences from outside of the family-of-origin. If we are able to think independently, we soon understand that theoretical combinations are unlimited.

Narrative-Emotional Therapy

As Peter Fonagy has stated (Fonagy, 2016), it is often the case that the more experienced we get as practitioners, the less effective we become—because we are more apt to categorize based on our considerable clinical experience. When we are newer to the field, we are less sure of ourselves and we treat each of our patients as a new and unique individual as a matter of course. It's when we start to know our way around that we lose our way. The realization of this can be disorienting. It often comes as we are finally coming into our own as therapists. This is why it is essential that we keep learning from our colleagues and from our patients. They need us to be authentic with them and to be able to tolerate, along with them, the discomfort of being in a place of "not knowing."

It can feel like we are doing nothing, and this is particularly scary when we are supposed to be "fixing" our patients—when we apply a medical/disease model to mental health. It is when we have lost our sense of geography that we may, ironically, be at our most therapeutically effective. It is at this point that we as

practitioners are not role-playing our teachers or mentors or taking refuge in the distance that our professional nomenclature or technical training allow us.

As we come into our own immediate state of authenticity with a patient, it can feel like the safety net is gone. It's not dissimilar to the way that we feel the first time we realize our parents are fallible. Developmentally, that is often our first inkling that there are no absolutes. It is as seismic a shift in consciousness as the first inklings of the integration of the "bad mother." So, as I feel myself coming into this place of maturity, how can I feel grounded as I move forward professionally? I am increasingly finding myself drawn to a model of narrative-emotional therapy that I am utilizing to work with patients who have borderline organization or borderline personality disorder (BPD).

A possible model for a narrative-emotional response loop in borderline patients might take the following route: The patient experiences something ("the story") and has to make a lightning-fast series of choices leading to the way that the story of that experience is represented to herself narratively. This is the first step in being able to respond to the story, "speak" of it, categorize it, and file it away into the "portfolio" of the self, i.e., the historical identity and emotional memory that becomes a part of the master narrative of the self).

The initial task is to process the experience and assign a category to it that is congruent with the rest of her historical identity. This requires processing, containing and rejecting all of the other possible categories and interpretations. This necessitates a default because the possibilities for conceiving of this narrative are limitless. Sorting through other possible narratives is an overwhelming task for those with a borderline organization of the self. To compensate for this, the emotional response and consequent narrative result begin to develop a shortcut. In borderline patients, this shortcut is stuck at an early developmental place of un-integration.

This might partially explain the tangential organization and the labile affect that prevails when these patients try to relate or recount a narrative experience in a linear fashion. This also helps to explain the dramatically heightened awareness these patients have of the most minute shift in our own affective mirroring of patients' narratives. The patients' already-fractured identities are thus reinforced by their "reading' or "misreading" of therapist responses. It is for this reason that the therapist or counselor must maintain a steady, neutral affect while simultaneously being empathic, warm and receptive.

Too much or too little affect will both be magnified by the patient's subjectivity and cause the patient to either sense engulfment and retreat or sense an abandonment that will activate a depressive position. These patients have not yet developed the capacity to self-regulate their emotions. An important skill in working with these patients narratively involves bringing the patient back to the main narrative thread. This aids in affect-regulation and in the navigation of default behaviors these patients employ to avoid frightening emotional states.

As they move forward with their narratives, they become better able to tolerate negative affective states—as well as perceived negative affective states in the therapist. This ability to tolerate imperfections in the therapist and to express dissatisfaction with the therapist while maintaining the therapeutic bond is a strengthening exercise that begins to have a profound effect on patients' lives outside of the therapeutic hour. Patients begin to have a sense of themselves as the center of their own agency. This in turn creates

the ability to strengthen and eventually maintain boundaries, which are always highly permeable and fragile in patients with BPD.

The importance of the therapeutic dyad as an echo of the original caregiver bond has become a commonplace of psychodynamic theory. Common to many therapeutic practices today is a basic assumption that human connection in a relationship free of obligation and contained within clear and specific boundaries has the power to heal psychic wounds. This position underlies Interpersonal, Existential, Attachment, Object Relations, and Self-Psychological theories. As a practitioner, I subscribe to this philosophy. I believe we are all born with the capacity to be self-regulating and self-actualizing. The false self emerges as we strive to assimilate and accommodate the deficits of our caregivers and place ourselves in the double-bind of jettisoning our inner authenticity and wholeness in order to protect those we cannot survive without. This false self that emerges is not contained within the realm of individual interpersonal relations. It negatively impacts institutions, damaging the landscape in which individual development takes place, and creating dysfunction at both the intergenerational and international level.

One of several theoretical models that supports this view is a systems-theory approach, which emphasizes the inter-relational field in which neurosis of the designated patient forms (Satir,1978). Less attention is paid to the sociological implications of the landscape, a view that lies at the origins of the psychoanalytic project and was only jettisoned in response to internecine conflict within the early psychoanalytic community itself. That this community should have evidenced the destructive patterns it identified within its own theoretical framework is one of many ironies in the history of psychoanalysis.

Social Theory or Psychology?

My world while coming of age was inhabited by people who had fled the Holocaust and many among them were psychoanalytic practitioners and political theorists. They inhabited a *Zweistromland*—a land between two streams. Their interest in the here-and-now of the moment was also a psychoanalytic living-in-the-moment, a focus on the here-and-now (Längle, 2012) so as not to dwell in the past. I spent decades working with concentration camp survivors in the U.S. and in former "Iron Curtain" countries such as Poland and the Czech Republic in the 1980s and 1990s. I was struck by similarities in markers for resiliency after trauma and loss that I have seen in other situations with individuals who are dealing with "ordinary" issues, such as failing health or aging. Those who focus on the present fare better psychologically (and physiologically) than those who dwell in the past, although it is often goals informed by the past that provide the motivation for the here-and-now stance.

Attachment, Identity and Survivor Mentality Across the Generations

Survivor mentality means loyalty to the story of suffering and survival. That loyalty is absolute. It employs shame, grief, loss, guilt, and anger. Those stories become intertwined with expectations about achievement, obedience, success and failure. Children raised in families with historical trauma feel the weight of responsibility for redressing the balance of loss and setting things right. We challenge the primacy of the oppressor or perpetrator through reenactment [unpack this statement]. This is not simply a Freudian reenactment. It is not just a replay in the hopes of finally "getting it right" amid the dangers that finally getting it right would expose us to—the annihilation of those to whom we are loyal. This is more complex.

By reenacting the story time and time again and creating situations into which we are vulnerable to reenactment, we remain loyal to the story, to the master narrative of suffering. Historical trauma creates a unique constellation of behavioral and emotional issues that are rooted in this idea of loyalty. It becomes the source of identity as well as the fabric of our national culture, whether this idea of "national" is rooted broadly around a specific nation-state or in a more amorphous vision of cultural affiliation or identification as nationality. This idea of cultural nationalism is on display when I work with socioeconomically challenged addicts and their families. There is a perverse cultural pride in remaking a part of the community of addicts, enforced beyond a mere psychological reading by addicts who come from families in which their parents and even grandparents were addicts.

A word about what is said and what is unsaid in discussions around identity and cultural trauma versus identity and trauma (i.e., Judith Herman) might be useful here. In the more reductive version, there are social conditions that create dysfunctional behaviors resulting in attachment traumas—all of which are exacerbated by poverty, violence, sexual abuse, drug use, and incarceration. When an entire nation has been traumatized, there is something that stands out in the families of those who have specific trauma that transcends the historic communal narrative. The world is split into idealized and persecutory aspects. It is persecutory because one must rid oneself of the bad experience, of the bad self-representation that accompanies the bad internal object representation of the bad mother—by projecting it out onto the world. It's "out there," it's not "in here"--one's bad internal self-states. This process works much like that of an animal who runs away when it is in pain, not understanding that the animal itself is where the pain is located.

Psychoanalytic object relations theory, depressive position, narcissistic grandiosity

In session, we find role reversals (dependent/devaluing). Those that occur in psychoanalytic experience also occur in political experience. We are working with identity diffusion to normalize identity (the diffusion is the projected all good and all bad). The dependent position ("don't abandon me, I can't survive without you") is in conflict with the empowered position ("you're here and as a result I feel strong and don't need you"). The go-away/come-back relational rubber-banding impairs these client's ability to make transitions easily. Any change becomes an arena in which these conflicts have to be played out, either by delaying, avoiding, entrenching, or, conversely, jumping in with no warning and no preparation, and other impulsive behaviors.

My environment led to two separate academic foci. First there is Holocaust history, with an emphasis on culture and identity. Second, there is psychoanalysis, with an emphasis on what is sometimes termed "psychosociology"—an interdisciplinary mode of applying psychoanalytic concepts to the larger social and historical field in which the self exists. My interdisciplinary background has provided me with a holistic view of individual development and insight into the kinds of disorders that develop when the context that has supported the trappings of the false self is ripped away.

I am particularly interested in the sociologically determined base of many of the identity errors clients and patients present with. I was fortunate in working with key political psychologists from the post-World War II era when I was young, and this has informed my theoretical groundings. I completed my doctorate under a protegé of the late Nevitt Sanford, a primary author of the first major study on authoritarianism

(Adorno et al., 1951). The other work that has influenced my psychoanalytic thinking is from political science: Hannah Arendt's *The Origins of Totalitarianism* (1951). Both of these works investigate failures of individual accountability in terms of projection, splitting, and exteriorization, even though these terms are not spelled out.

I am interested in the ways that these landmark works in political theory are applicable to individual psychology, particularly within a framework that supports the continuation of the false self along with the divestiture of individual power that accompanies mass movements. There is a question that is always pertinent at both the individual and social or national level. We must ask what it is in a particular context that drives the mechanism of maintaining the false self for the sake of a maladaptive connection? This is a connection that makes us repeatedly relinquish our autonomy to the very forces that will harm or destroy us. It is the fear of allowing the authentic self to emerge. It is the necessary grieving process for absolute merger with an all-good introject that must accompany it that is painful. It is painful enough to keep individuals enmeshed in habits, systems, relationships, and beliefs that are patently harmful to them. As Arendt writes of totalitarian organization (in one of the many German editions not translated into English):

> The outstanding negative quality of the totalitarian elite is that it never stops to think about the world as it really is and never compares the lies with the reality. Its most cherished virtue, correspondingly, is loyalty to the leader who, like a talisman, assures the ultimate victory of lie and fiction over truth and reality (Arendt, 1951).

It is the false self, predicated upon the same fiction, that aids in this victory, precisely because of the feeling of strength that accompanies the idealizing merger. The fragile self is subsumed in a mass, whether that mass is socially or ideologically driven, that impedes the access which individuals have to their inner strength and authenticity.

Psychoanalysis and "the Clinic"

At its outset, both psychoanalysis and social progressivism "conformed to the social-democratic political ideology that prevailed in post-World War I Vienna" (Danto, p. 2). Services were provided to the working classes and the poor by the early psychoanalysts. Psychoanalytic treatment centers promoted the idea that "psychoanalysis was supposed to share in the transformation of civil society" (Danto, p. 3).

In the face of our current opioid crisis, which is inextricably if unwittingly tied to this nation's political and economic agenda, we would do well to revisit the idea of analytically oriented interventions. That the atomization of the individual and the intergenerational trauma of poverty, as well as the various financial and political agendas of the pharmaceutical industry, have resulted in mass addiction warrants addressing inequality from both a psychoanalytically informed and psycho-social perspective.

The Emergent Self

That the purpose of life is to self-actualize is a tenet of Existential, Humanist, and many other schools of psychoanalysis, spirituality, and philosophical thought. However, if we are operating within the framework of the false self, we cannot self-actualize, because there is no authentic self that can be operationalized. A primary goal of psychotherapy is to uncover an emergent authentic self. We are to

provide nurturance and support for new growth, until that self can be stable enough that the client or patient can take responsibility for it and ownership of it. This idea of the authentic contains within it echoes of what mass movements appeal to—idea of an unsullied self (or nation) prior to contact with dangerous or disabling admixtures.

Individual psychological development owes as much to the meta-context in which it takes place (historical, social, economic, political) as it does to the micro-context of our earliest attachments: the initial dyad in which capacities for self-esteem, love, and connection are formed. Political psychology owes much to the pioneering work not just of Erik Erikson and his psycho-historical approach, but also to Alfred Adler (Maniacci et al, 2013), who understood that the individual develops in a social context. Many of the concepts that were developed by Adler, such as holism, emerged within the context of a Viennese leftist orientation during a period in which Freud had abandoned the idea of "the clinic" as a psychoanalytic space for socially and economically disenfranchised classes. It was replaced in favor of an approach that unintentionally led to an elitist view of psychoanalysis that has had repercussion in terms of treatment options for the working classes and the poor to this day (Danto, 2005).

Idealizing Transference and the "Good Enough" Psychotherapist

Ego-personification describes the way that the false self makes up for failures of empathic attunement in the primary caregiving bond. An idealizing transference is created that has as its underlying goal a twinship (Almaas, 1996) that will provide a sense of being "real," of legitimizing and authenticating the false self. This type of non-pathological idealization is normal in youth and explains the drive to join groups, causes, and other modes of expressive action in which idealization is applied to group membership. However, it becomes pathological if the false self carries this desire through into a kind of delayed or prolonged adolescence or disowns responsibility for actions. One of the common results of this type of idealization in the presence of an historically absent/invasive parenting style on the part of the primary caregiver is often narcissistic personality disorders. These disorders include elements of grandiosity, a sense of entitlement and "specialness," and oppositional-defiant disorder (Kohut, 1984).

Often, clients presenting with issues that stem from anxious/ambivalent attachment patterns created by absent/invasive parenting styles benefit from cohesion therapy (to address both grandiosity or its shadow "other," which is imposter syndrome) combined with recognition of attachment deficits in the context of a self-psychological cycle of rupture-and-repair within the therapeutic dyad. Object-constancy failures are also addressed (Mahler et al, 1979), with a blurring of the lines between the all good and all bad partial object representations (Klein, 1964). These are representations which lead to many of the modes of black-or-white thinking that characterize populist and extremist movements (xenophobia-producing rigidity and paranoia among them).

The derailments caused by failures of empathic attunement at key developmental junctures in infancy and early childhood are rectified within the therapeutic dyad (Kohut). Habits are created to maintain the proximity of the original wound. By extension, those habits can be broken that continue to provide "oxygen" to the shadow of the primary caregiver in the hope of retroactively repairing the failure. Patients can then start to progress to a state of self-actualization informed by reasonable, achievable goals and increased satisfaction with "what is." In this way, the fantasy of what the self might one day become and the reality of what the self can realistically and legitimately become are fused.

The client can gradually begin to dismantle partial-object shadow expectations. This is particularly useful in working with addicted or substance-disordered clients, who have an entire repertoire devoted to maintaining an early failed empathic bond. This method can also be used with narcissistically organized patients and can break through defenses such as grandiosity, projective identification, and splitting. Patients will often present with confusion when the depression they have kept at bay begins to weaken these defenses. The imposter syndrome is seemingly at the other end of the spectrum, although it is effectively a shadow syndrome of narcissism. This syndrome often is accompanied by "gaslighting," and pathological accommodation in relationships that are distinguished by abuses of power or power imbalances. The point at which the holding environment provided by the therapeutic alliance has become sufficiently strong to contain the client's anxiety is the point at which ownership and responsibility can start to create an authentic, organic identity and the process of ego-personalization can begin.

The Social Field and Consensus Consciousness

In Adler's social field theory, soft determinism leads to his premise that psychopathology is created by the individual in order to evade basic life tasks. In my work with BPD patients on methadone maintenance, many issues arise at the point at which the success of the therapeutic dyad begins to arouse anxiety around a sense of striving that can cause panic for these patients. Idiographic orientation (Adler, 1938) concerns the specific triggers of the diagnosis. Question arise regarding what circumstances (in what field) the diagnosis manifests.

These always take place within the "consensus consciousness" that our society elevates to the status of the real (Almaas, 1996). Part of discovering the nature of the field can be achieved through the use of therapies such as those of Eugene Gendlin. Using experiential focusing, Gendlin explores the "felt sense" of a given emotion at both the bodily and cognitive levels. This sense is fine-tuned through a process of ongoing reciprocity between patient and therapist. An additional mechanism of change includes recognizing and acknowledging behaviors that are maintained within the therapeutic dyad. As Adlerians (Maniacci et al, p.59) point out:

> People form maps of their worlds. They then act "as if" those maps were accurate representations of reality. The extent to which they cling to their maps is what is of interest to Adlerians. No map ever can be more important than the terrain itself, or survival is at risk. … Adlerians tend to analyze how useful people's maps are, given the particulars of their lives. … Psychopathology can be conceptualized (in part) as a matter of "goodness of fit" between the terrain and the map. The better the fit, the less likely behavior will appear as maladaptive.

A protégé of Viktor Frankel, and founder of his own brand of existential analysis, Alfried Längle proposes that psychopathology exists when goals and identity are at odds: "something doesn't fit" (Längle, 2014) and dysfunction arises. Another way of thinking about this is in terms of assimilation and accommodation to external stimuli that emanate as either authentic synthesis or inauthentic appropriation. Appropriation creates a "bad fit" between the map and the field, or between the legitimacy of the environment and the authenticity of the self. What happens when forces beyond our control alter the terrain? What is the impact of loss, illness, economic downturns, war, exile, the destruction of a way of life, or a radically altered political system? What factors predispose some people to self-destruct and others to show resiliency?

Methods work in the field of psychotherapy that promote a therapeutic alliance—especially when this alliance produces a safe holding environment. To borrow Bowlby's phrase, (Bowlby, 1988)) a "secure base" helps to create a climate in which the patient learns to take responsibility for "what is." The secure base enables a patient to view "things as they are" in the present. They are able to distinguish this view of reality from self-recrimination. They leave a world that is based on shame.

It is this foundation that provides support for applications of techniques common to existential therapies. The stages of mature identity development through integration begin with fragmentation and ideally end with synthetic cohesion. Intermediate stages necessarily encompass the struggles of individuation. These stages encompass the acceptance of those parts of the self that one has gained historically but have not easily assimilated. These parts may have been externally imposed and may forever be at odds with the ideal or authentic self. This is something that this theory of maturation has in common with self-discrepancy theory as well as "theories of ego" and ego psychology (Hartmann,1938). The task of incorporating these aspects and taking ownership of them is a goal of the maturation process. This process can be reinforced through a positive, healthy, equity-promoting transference that is neither idealizing nor devaluing. It is not seeking twinship. It is this process that helps the individual to question the "consensus consciousness" (Durkheim, 1893) in which we collectively exist and in which much of the draw to unhealthy behaviors and mass movements lies.

Conclusion

I work with clients at the nexus of social theory, political history, and psychology. My theory of change is informed by my background in psychosociology and many of the "intellectual offspring" of the various attempts to fuse Marx and Freud over the past century. Although my psychoanalytic training is grounded in attachment theory, my social theory training took place at organizations with a legacy of interdisciplinary thought that bridges the European origins of the soft sciences and their application and reinterpretation in response to totalitarianism.

My experience in a clinical setting has only strengthened my belief in the importance of psychoanalytic process being made available to the disenfranchised. The history of modernity is replete with examples of dangers associated with the stratification that is an inherent and necessary condition of capitalism. The mass movements that have emerged as a result of capitalism succeed in gaining adherents by breaking through the atomization that capitalism requires. Hence the frequent recourse of these movements to nativist themes such as race, blood, and soil. It is the individual's rejected aspects of identity and the creation of "otherness" as a form of impoverished individuation that contributes to individual "poorness of fit." Far more dangerous are tendencies in the social and political sphere that lead to devastating implications for us all. Only by creating safe spaces for individuals to discover and assert their authentic selves in the here-and-now can we hope to rescue ourselves as a global society.

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