How to Talk to an Obsessive-Compulsive Personality

Joan Jutta Lachkar, Ph.D.

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Created in the United States of America

To my beloved husband, Richard Seigle
My daughters, Shari, Pamela and Nicole, and grandchildren

Table of Contents

Acknowledgments

I would like to start by acknowledging the little girls in my first ballet class, who gave me my initial glimpse of narcissism when I was age 7. Although I did not know the term narcissist existed, I quickly diagnosed them as little "showoffs." As they grew into beautiful budding ballerinas, their bodies changed but their arrogance remained. I learned early on that I could not talk to them as I did my regular playmates because often, they would not respond; and if anyone said anything unpleasing to them, they would get highly insulted. Little did I know that this would lead to an array of narcissists in my adult life as a therapist and author, including the artist narcissist, someone

who requires a certain amount of narcissism to pursue his or her creative endeavors.

Though this book expands on my previously published work, it has an entirely new focus. Many of the same dedicated friends and colleagues have remained loyal and supportive as I continue this journey. Many thanks to my respected scholarly partner, Richard Seigle, retired psychiatrist and distinguished artist; the deceased Peter Berton, distinguished professor emeritus at the School of International Relations at the University of Southern California, who was most instrumental in helping me with the chapter on handling cross-cultural problems and pitfalls in couple therapy. I believe I have learned more about Japanese, Russian, and

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Introduction: How This Work Began

Wash Hands! Social Distance! Use Masks! Don't Touch!

Welcome to the land of obsessive-compulsives, a land that houses some of the most brilliant people on the planet—scientists, doctors, physicists, lawyers, financiers, accountants, artists. As accomplished as they are in their respective fields, many of them lack the emotional stability that an intimate relationship requires. Also within this land dwell the hoarders and collectors.

Never has the challenge of this disorder been so widely acknowledged by clinicians, scientists, and the public alike. Throughout the globe, hospitals, clinics, and mental health professions

are providing safety measures to combat this ever-growing disorder. What a timely subject! With the onset of the formidable Covid-19 virus, we have obsessive-compulsives everywhere! In fact, most of us have become a bit OCD because of the pandemic. Masking, constant hand washing, and social distancing have become the norm as the world experiences an unprecedented crisis that has killed millions and infected millions more. Just when it looked as if the pandemic was subsiding, people throughout the globe were again requested to wash hands carefully and repeatedly, wear masks, keep their social distance from others, avoid touching objects, and, in many cases, quarantine.

For the obsessive this may be familiar territory. There are questions about how much is

delusional and how much is reality based (listening to the authorities, not one's own delusions). In clinical practice, even without the "virus," those with OCPD have their own guidelines regarding cleanliness. Contamination for them is not an external "virus" but a virus of emotionality. One distraught woman quipped, "Ironically, now the hoarders, obsessives, handwashers, and touch-me-nots are saying, 'I told you so! You were all out of everything while the markets were out of stock!'" What was considered ego dystonic could now be seen as ego syntonic (in concert with the environment). Said one friend, "Hey. look, the compulsive is smarter than all of us; at least he has toilet paper!" But there is a difference! The Covid-19 virus is externally imposed, whereas the obsessive "virus" is internally imposed.

Shifting Focus

Until recently the narcissistic personality disorder has garnered all the attention. People were using the term as a household word. However, a new character has now appeared on the clinical stage, one that has begun to give the narcissist serious competition as far as attention: the obsessive-compulsive personality.

> *Yes, there is a practical side that collects and saves, that makes you feel safe and surrounded by objects. But the other side of you feels lonely and isolated.*
>
> *She gets overly emotional, makes constant demands of me, gets hysterical if she doesn't get her way.*

I never paid much attention to obsessive-personality disorder until I married someone who had it and became a therapist. It may seem

strange that someone like me would be writing a book about obsessive-compulsives. I've had many relationships with OCD types in my life, in addition to having a Polish immigrant German-Jewish mother who insisted her daughter marry a doctor: "At least they make a living!" Also, I must not forget all the years of ballet training, with Russian master-class teachers hitting my leg with a stick if I was not in the perfect "fifth position." So, what would ordinarily seem strange to most people felt perfectly natural to me. It was not until clinical practice opened my analytic eye that I was flooded with awareness of the complexities involved in dealing with obsessive-compulsives.

Why should I express emotions and sound like my hysterical mother!

Obsessive-compulsive types are not clear and concise entities. Their traits often tend to blur into other personality disorders—for example, a narcissistic obsessive. When I began delving into these personalities, I started with narcissists and borderlines, Later, a colleague and good friend suggested I go beyond the narcissistic-borderline couple described in my first book (Lachkar, 1992) to other types of relational love bonds. For example, what happens when an obsessive-compulsive hooks up with a histrionic, a passive-aggressive, or caretaker types.

Without sounding narcissistic myself, I took the liberty of expanding narcissists and borderlines into eight different types and describing those partners to whom they were

attracted. So here I had all these varying types of narcissists and borderlines and wasn't sure what to do with them. Should I just throw them into a chapter and let them fight among themselves? This motivated me to originate two special "languages"—The Language of Empathology and the Language of Dialectics—to make communications with these personalities more "user friendly" as well as more effective. These languages are useful not only for therapists but for the persons who live with or interact with narcissists, borderlines, and obsessive-compulsives.

> *I love and respect my husband but as brilliant as he is he needs an emotional GPS.*

The major thrust of this book is to help therapists, patients, and others who interact not

only with those who have a personality disorder like OCPD but also for those living in an interpersonal world—for example, dealing with a disgruntled neighbor. Throughout this text, including the cases, there are examples of how the specific communication styles of the Language of Empathology and the Language of Dialectics have applicability to the obsessive-compulsive, in order to meet and match their repetitive behaviors and paranoid anxiety regarding cleanliness and perfection.

Part One
Overview

Chapter One

Overview of the Obsessive-Compulsive

One mind diverged into two: one that seeks perfection and cleanliness and the other that roams in the mess.

Differentiating Obsessive-Compulsive Disorders from Obsessive Compulsive Personality Disorder

Those with obsessive-compulsive personality disorder (OCPD) share many features with those who have obsessive-compulsive disorder (OCD). According to the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders (APA DSM-V, 2013), these traits

include a strict adherence to perfectionism, rigidity, and inability to show affection. However, obsessive-compulsive personality disorder (OCPD) differs from the obsessive-compulsive disorder (OCD) in that OCD is an anxiety disorder. The main difference is that those with OCD have thoughts they know are intrusive and do not want, while those with OCPD believe their thoughts and behaviors are justified.

Devoid of feelings, those with OCD revert to compulsive cleaning, washing, checking and rechecking, and other repetitive acts. This pervasive preoccupation with orderliness, perfectionism, and ritual comes at the expense of flexibility and empathy. Patients with OCD experience intrusive thoughts and obsessions

that drive their ritualistic behavior. The OCD is riddled with anxiety and often uses these ritualistic acts in the attempt to reduce their anxiety. People who suffer from this disorder have a great deal of shame, which often leads them to withdraw and isolate themselves. Their obsessions may include concerns about germs and the fear that they will contaminate themselves and others. To guard against the shame of having emotions and feelings, they resort to compulsive cleaning, handwashing, praying, counting, checking/rechecking if they have locked their door or turned off the oven, and engaging in other repetitive behaviors that include the collecting and hoarding of objects.

Honey, We're late! You don't have to check the door three times.

In addition to fear of contamination, common OCD themes include self-doubt and distrust, emotions that are felt to be dangerous and persecutory. Obsessive-compulsives also have a constant fear of being harmed, as well as disorganized fears that other people's thoughts or acts will be harmful or bring a state of disarray to their lives. Such behaviors can be extremely distressing and debilitating in intimate relationships.

As for the OCPD, their relentless scheduling and compulsive need for orderliness, paradoxically, can create a host of other problems. They are the workaholics and are masochistically inclined to sacrifice themselves, their lives, their children, partners, and families. A punitive superego reminds them of disaster

lurking everywhere. Ironically, they can never be perfect enough to satisfy themselves. On a more positive note, because of their obsession with work, they are often successful in business and other professions, including the arts.

OCD involves ego-dystonic thoughts. Those who have OCD are aware their symptoms are worthless but cannot control these distressing behaviors. Their anxiety often involves the need for medication. OCPD involves ego-syntonic behavior, and the behavior of those with OCPD is consistent with their skewed worldview. Both OCD and OCPD are often associated with rigidity, inflexibility, and stubbornness; however, the former is not functional, whereas the latter is. The obsessive-compulsive is driven by a

focused work ethic and principles and has little regard for their partner.

Obsessive-compulsives experience the state of dependency and vulnerability as weakness. Emotions are felt to be messy, filthy, disgusting things, suitable only for evacuation, splitting, and projective identification. To counteract the dirtiness of emotions and their abhorrence of ordinary human needs, the obsessive-compulsive focuses on cleanliness and orderliness.

It is you that is the messy one! I am pure!

Why should I express my feelings and open up that can of worms!

Sam Vaknin (2007) noted that people with obsessive–compulsive disorder have obsessions and compulsions that are mostly about fear of

losing control over their external objects. They are often viewed as rigid and perfectionistic, lacking flexibility and spontaneity. They reflect a constant concern that something will go awry. To counter these anxieties, they rely on ritualistic acts and exhibit an obsession with lists and order to the exclusion of all else while ignoring the needs of others. Compared to other personalities in the DSM roster, the obsessive–compulsive personality has a more developed and well-integrated ego, a better tolerance for anxiety and impulse control, as well as a harsh but well-integrated superego. Some obsessive parents project onto their children that vulnerability is bad and negative.

> *My military father used to say, "Only babies cry; you will never grow up to be a man"!*

Many people who struggle with obsessive-compulsive personality disorder (OCPD) unconsciously sabotage the very thing they strive to achieve. People get annoyed with them because of their constant delaying tactics, lateness, procrastination, and misuse of time. They frequently have difficulty completing anything because they become engrossed in tedious and minute aspects of tasks—for example, painstakingly redoing a schedule or a file while overlooking major tasks that should receive priority.

> *One lawyer patient stayed up night after night finalizing the "perfect" brief. By the time he got to court, he realized he had forgotten his briefcase.*

Partners of Those with Obsessive-Compulsive Personality Disorder (OCPD)

All She Does is Nag! Nag! Nag!

Often, those with OCPD are unaware of the stress their unreasonable demands and preoccupation with tedious tasks places on their relationships (e.g., leaving no time for leisure, hoarding, and withholding money). Invariably, they put partners down for having emotional needs and desires, keep them on hold, and never have enough time for them. Because they confuse needs and desires with dirt and disgust, those with OCPD find justification to work, work, work under the guise of efficiency or contributing to the "good cause." They avoid intimacy, and partners often get disillusioned because obsessive-compulsives are overly

methodical, withholding, fuzzy, and unemphatic, making it difficult to sustain a relationship.

> *My husband cares more about his schedule than coming to the wedding on time. We never go on vacation for there is never time! He won't French kiss or have oral sex with me because he finds women's vaginas unclean!*

Although this book focuses mainly on the obsessive-compulsive, it recognizes that those with OCD and OCPD do not live in a vacuum. There are many different types of obsessives, just as there are many different types of narcissists and borderlines. Franz Kafka's *The Hunger Artist* is an excellent example of how various personality types—mainly narcissists, borderlines, and OCPDs—overlap. The central character in Kafka's story is a skinny, frail man starving himself publicly in a straw cage. His

narcissistic self takes delight in the onlookers who come to stare at this unique sight. He is narcissistic in that he craves constant adulation and validation. He needs to feel that he has a special art talent that no one else can perform as well as he can, an art form that keeps onlookers awestruck and mesmerized. His borderline self dwells in pain, and he will do anything to keep the onlookers enthralled to avoid abandonment, even if it means sacrificing his own survival. When people start to lose interest, he feels abandoned and tries harder to attract others with his uniqueness and suffers even more pain. His identity lies in being a professional faster. His obsessive self revels in the compulsion not to eat: "because I have to fast, I can't help it." He delights in this and holds himself in high esteem for his skill and persistence. He is obsessed with

the people who come to see him. All he can think about is his fasting. He is proud of the effect it has on people. He sees himself as the ultimate hunger artist and pushes himself to the limits of fasting in order to garner more fame (Seigle, 2021 personal communication).

There are also many different types of relational bonds: for example, what happens when an obsessive-compulsive hooks up with a histrionic? One can imagine what the endless "nagging" and histrionic outbursts and demands do to someone with OCPD. They are obsessed with their possessions and are terrified by change. They tend to cling to objects as if they were priceless possessions.

> *An obsessive-compulsive neuroscientist married to a histrionic wife was considering remodeling their home.*

However, when the architect told him he would have to remove his objects and possessions, he cancelled the deal —much to the dismay and disappointment of his wife and kids, as well as the contractor and architect who spent long and tedious hours drawing and refining the blueprints.

The bitter paradox is that although the obsessive-compulsive strives to have high moral and ethical standards, their defenses sabotage the very thing they wish to achieve. In some cases, an individual can manifest both OCD and OCPD. In conjoint therapy I take the liberty of recognizing this duality or crossover with OCD. There are those who struggle with OCD states, traits, and characteristics but do not necessarily meet the diagnostic criteria set out in the DSM-V.

A middle-aged woman about to remarry almost broke ties with a friend she has had for over 25 years. She complains: “My friend won’t come to my wedding even though it will be small, only immediate family. We will wear masks and practice social distancing! I know how OCD she is. I knew she would refuse!” I respond: “You and your friend are very close but there is a greater force overpowering her love for you, an inner force she cannot control. The client retorts, “But later I found out she went to her daughter’s 21st birthday!” I remind her that there is something that can even overpower her friend’s OCD: the family!

Partners and family may be completely baffled by how obsessive-compulsives can be so generous in some cases and so stingy in others.

He is worth millions, and won't even buy new furniture for his house.

One woman attended a posh benefit luncheon with her fiancé, whom she described as "cheap and withholding." She had just asked him to loan her a few hundred dollars to get through the month, but as usual he responded that he couldn't afford it. She was astonished when a speaker appeared at the podium and praised her fiancé as one of the organization's most generous donors. He was even honored with a diamond pin for his contributions of at least $100,000 annually. Her first instinct was to say, "Hmm, how come you can give all that money to a charity, and when I ask for a few hundred dollars, you refuse?" Instead she waited for just the right moment and then asked again if she could borrow a few hundred dollars. But,

like a kid caught with a hand in the cookie jar, she felt shamed for asking.

Freud (1909) noted that money should be used for a good cause but that it can also be a form of anal retentiveness.

Both those with OCD and OCPD typically choose to bond with objects rather than people, which helps explain their collector/hoarder behavior. Some obsessive-compulsives are pack-rat collectors who cannot discard such items as old papers, rocks, coins, wires, or dented lampshades that often clutter their space. They are inconsiderate of the needs and desires of others and are oblivious to the problems that their rigid scheduling and compulsive need for orderliness create for those who live with them. The difficulty they have in disposing of worn-

out, worthless objects occurs because they use their clutter to block intimacy.

> *I can't even throw out the trash without her rummaging through it.*
>
> *I guess it is hard to be with a man who is brilliant, successful, well known, and emotionally not available at the same time.*

Enter the V-Spot and the Languages of Empathology and Dialectics

The V-spot is a term I devised to describe the most sensitive, most vulnerable area of the psyche, also known as the archaic injury. Everyone has a different area of vulnerability or V-Spot. The way a narcissist gets emotionally injured is different than the way the borderline is injured, and different than the person with OCPD, who gets injured when coping with

anything that is less than perfect. A narcissist may become personally injured when not properly mirrored or when not appreciated, and when his or her sense of specialness feels threatened. The OCPD could care less about appreciation but is more concerned with fear of intimacy and emotional contamination.

The reader must keep in mind that these personality types are not clear, distinct entities. They tend to vacillate and blur into many other personality disorders. But for our purposes here, recognizing these distinctions provides an entrée to understanding various communication styles. For example, the obsessive may share many of the dynamics and qualities of the narcissist's grandiose self but is more overwhelmed by emotions, whereas the narcissist will withdraw if

not properly mirrored or getting the attention they require to maintain their self-object needs.

To make communication with obsessive-compulsives, as well as those with other disorders, more concise, effective, and pithy, I originated two special "languages": the Language of Empathology and the Language of Dialectics. They are formulated to make communication more "user friendly" for both the therapist and those who come to therapy to find ways to live in relative peace and harmony with their OCD, narcissist, or borderline partners. Upcoming chapters will further elucidate the concept of the V-Spot and the languages of Empathology and Dialectics.

Mr. and Mrs. R: The Robotic Male the Maven (reexamined)

This case is an illustration of what happens when an obsessive-compulsive narcissist and a borderline, histrionic wife get together. It illustrates how their primitive defenses get in the way of romantic love. In the "dance" of the couple, each partner projects some unresolved developmental parts of themselves. Mrs. R entered into treatment feeling vastly frustrated regarding her husband's preoccupation with cleanliness and perfectionism, as well as his inability to be intimate, let alone romantic and sexual. (The inspiration to write this case came after reading an article on NASA's new solar mission, an orbiter called MAVEN.)

Therapist: Greetings! So who would like to start?

Mrs. R: I would. My husband is a well-known and renowned scientist in the field of space exploration. As much as I love and respect him, I am contemplating getting a divorce. He never expresses any emotion. He is not romantic and is very uninvolved when we finally do have sex. He accuses me of being too needy, being a nag, and being too emotional.

Th: (Listening; already getting the sense that her husband may be OCPD but trying to listen without preconception.)

Mr. R: She is too emotional. Her emotions kill me. Why can't she just talk like a normal person? She whines, she weeps, she yells, and constantly complains that I never listen to her.

Mrs. R. When we have sex, he just sticks it in, comes, and then in some

perfunctory way plays with me. But I am always left frustrated.

Th: So you are saying you're upset because you would like more intimacy.

Mrs. R. (Annoyed by therapist's remark). Of course, I would like that. Why do you think I'm here?

Th: You feel your husband has been a good provider, a good dad; you respect his brilliance and accomplishments as a scientist and aerospace engineer, but he's lacking in romance and passion.

Mrs. R. That's the point. I do love and respect him, but I'm tired of always feeling frustrated.

Mr. R. But not of complaining and bitching; I can't stand her overreactions and hysterical outbursts.

Th: Actually, your wife is not really complaining, although it sounds that way because for so many years you

have not listened to her. What you call complaining, I call needs!

Mr. R. Needs! That's for people who are sick. Needy people make me sick!

Th: Of course, that is why you are so obsessed with cleanliness. You feel needs are dirty and must be eradicated. Tell us more about the space mission.

Mr. R: (Suddenly comes to life) Oh yes. I am so impressed by how these men working on the project scrub and scrub. Cleanliness is crucial to avoid contaminating other worlds; contaminations from Earth could kill life forms on other planets, which would ruin any discovery. This is a space project designed to search for life beyond Earth, which requires unadulterated, pristine robots to go into space. There should be no water and heat contaminates from Earth if

they are to go to another planet that is cold and dry.

Th: (Intensely listening to the words; the therapist cannot help thinking this is his own internal heat of passion and emotions, which must be obliterated). So, you are really telling us how you feel about having emotions, that you experience them as dirt that must be eradicated. You would like to have a perfect internal spaceship that is totally "germ free." You also worry that if you allow yourself the emotions an intimate relationship requires you will sound like a histrionic manic.

Mr. R. (Obviously squirming with discomfort). That is a bunch of nonsense.

Th: But as the brilliant scientist, I thought you would be open to new ideas, and of course it sounds like nonsense

because these feelings are unconscious.

Mrs. R. See, now he puts you down the same way he does with me.

Th: Yes, but I don't make demands or complain. I am trying to explain how my idea may be something new to him, an idea that could be experienced as a springboard to exciting possibilities if he gives it serious thought.

Mr. R: I like the fact that you value and appreciate me. I wish my wife would react like that.

Th: Sounds like you are already making progress. You just expressed a real need, that you would like your wife to express more appreciation for you.

Mrs. R. I can do that!

Th: Great. Well, I see we have a lot of scrubbing and analytic cleaning up to do here, but in order to do it we have to stay on Earth. See you next week.

Both: We will be here.

Mrs. R: From Mars to Earth.

Th: (Both chuckle). See you both then.

Discussion

Using the metaphor of "space" and the language of empathology to avoid responding to Mr. R's attacks, we open up new "space," mirroring and appreciating his scientific mind. With the speed of a laser, the therapist moves from confrontation regarding his preoccupation with cleanliness to an appreciation of his work. "Tell us more about the spacecraft" (mirroring and providing the narcissist with self-object

needs). After gratifying his narcissism, the therapist is then in a position to address his obsessive tendencies and how his fear of germs parallels his fear of emotions and passion. In terms of technique, note that the therapist repeatedly refers to the thematic motif of "space" to bring Mr. R. into the transitional world of the therapeutic space.

Summary

This chapter describes the OCPD distinguishing it as separate from the OCD. I have referred often to the household term OCD with the awareness that most commonly my reference is to the OCPD. Unlike many other disorders with fear of intimacy, dependency, and vulnerability, the OCPD fears contamination. Ironically as much as they fear emotions, they

often hook up with someone like a histrionic personality disorder. His repudiation of her histrionics becomes a mockery of someone he would never want to be like. “Her outbursts like my mother disgust me!” To guard against the shame of having emotions and feelings, they resort to compulsive cleaning, handwashing, praying, counting, checking/rechecking and engaging in other repetitive behaviors that include the collecting and hoarding of objects.

Chapter Two

Different Types of OCPDs

There are many different kinds of OCPDs (2020) just as there are also many different kinds of narcissists and borderlines. As mentioned earlier, even though there are similarities between these disorders, there are quantitative distinctions. We see them everywhere, bullying people to maintain a perverse sense of perfection, power, and control. Those with OCPD are found in corporations, schools, and perpetrating domestic violence in the home; they're even found among dictators and, yes, serial killers.

It was Sam Vaknin's (2015) reference to differing types of narcissists and their link to the obsessive-compulsive that inspired me to expand the OCPD disorder to include:

- The Pathological OCPD
- The Malignant OCPD
- The Borderline OCPD
- The Depressive OCPD
- The Antisocial OCPD
- The OCPD the Artist
- The Cross-Cultural OCPD (see Chapter 6 on Cross-Cultural Couples)

The Pathological OCPD

Obsessive compulsives also differ from pathological narcissists in the way needs, dependency, and feelings of vulnerability are quantitatively experienced. For pathological

narcissists, dependency needs and feelings of vulnerability are equated with shame, impotence, and humiliation, whereas the obsessive-compulsive internalizes needs as dirty and disgusting, the equivalent of bugs and parasites squirming around internally.

I would never French kiss my wife and get all that gooey saliva all over me.

Pathological OCPDs are extreme in their behavior and interpersonal life. Although there are similarities to narcissists, they differ in that the narcissist has a highly exaggerated sense of self, always trying to prove their specialness and to feel the whole world centers around them. Similar to the pathological narcissist, those with OCPD lack empathy and have very little regard for the feelings or needs of others. The pathological OCPD could care less about being

special or being the epicenter of attention and is more driven by work ethics, cleanliness, and perfection. They are workaholics and inclined to sacrifice happiness, pleasure, and joy to engage in their ritualistic, repetitive, and compulsive behaviors. Objects become the replacement for love. While narcissists seek self-mirroring objects, OCPDs seek objects. One of the most dominant features of the OCPD is the tendency to hoard and often withhold money. Money is regarded as something to be saved and not used for pleasure. Some persons with OCPD are pack-rat collectors, hoarders, and clutter their space without consideration for those who live with them. Others are compulsive behavior types fearful of leaving the house until they check the house several times to ensure they have, for example, turned off the stove. Although,

generally speaking, they have no intention to inflict pain, their partners claim they are emotionally abused.

> *He is so critical of me. The other day we were going on a trip. I felt relaxed, happy-go-lucky, and all he did was pick on me and criticize me. "Why did you turn right instead of left? Don't you ever know where you are going?" But it didn't stop there; he just kept at me. "You should check these things out before you get into the car and start driving." When we go to dinner, he has to have the perfect table, usually close to the door so if there is an emergency we can exit quickly. Then when he orders he has to be assured and reassured that his food is compartmentalized, that the chicken should not touch the vegetables. Then when we get the check he examines it as if it were a bank statement.*

The Malignant OCPD

This chapter would not be complete without reference to the malignant OCPD. Many of us have had teachers, instructors, and authority figures whom we learn from and depend on to be caring; but at the same time, they can be cruel and sadistic. As much as they praise their victims, they also humiliate them. The film *Whiplash* (2014) is a good example of a music teacher who expected so much from his drummer student that his demands became too great for the drummer to bear. People in the entertainment industry can attest to the abuse and pain inflicted upon them.

> *My daughter was threatened that if she didn't lose twenty pounds, she would not be able to perform. Everyone was shocked; she looked emaciated and got very ill.*

The malignant obsessive tends to be malicious and sadistic. They are controlling, domineering, self-righteous, and think only about themselves (Kernberg, 1991a, 1991b, 1992; Vaknin (2015). They constantly impose and force their beliefs, traditions, and ideology on others and cannot tolerate anyone disagreeing with or questioning them. They will attack, shame, and humiliate anyone who defies their rule of authority. They are condescending and use incendiary remarks to inflame others. Malignant obsessives are subject to uncontrollable rages, typically lack compassion and empathy, have no regard for anyone other than themselves, and coerce others to reinforce their beliefs or talents (real or make believe). They are often abusive, envious of others,

selfish, manipulative, and only exist for their own self-serving purposes.

> *There I was in my music class. The teacher would enter the room and greet students as they walked in. Sometimes he would shake their hand or make some pleasant welcoming remark. When I walked in, I noticed repeatedly that he would turn away and act as though I were invisible. In class we would each take a turn to play a piece on our instruments. On a few occasions when it was my turn, he would say "times up." Another time I did play, and he cut me off, telling me I needed to practice more (but never gave me any instruction). I couldn't understand why I was being singled out. Suddenly I got a letter from Julliard congratulating me on my audition and how pleased they were to have a fine violist join them. One of my fellow classmates confided that the teacher did*

the same thing to another student, which was basically envy; he could not tolerate someone surpassing him or his daughter. Yes, you guessed it; of course, there was no congrats!

The Borderline OCPD

The borderline OCPD is distinguished from borderline personality disorder in that the borderline bonds through pain and revenge as opposed to the OCPD, who bonds through attachments to objects. They are the collectors, the pack rats, the addicts. These personalities are consumed by their objects and/or their addictions. They regard their internal emotional life as filthy and dirty and bond with objects as replacements for love and intimacy. One of the most puzzling and taxing things about the OCPD hoarders are the types of objects they collect and

are attached to—wiring, computers, disks; they often have a garage full of broken drives, radios, and television parts. In terms of communication, the borderline OCPDs are the covert communicators. Strangely enough, many are very high functioning and accomplished individuals such as doctors, businessmen, engineers, etc.

The Depressive OCPD

Another disorder the OCPD interfaces with is the depressive. The depressive OCPD is plagued by guilt and embodied by a harsh, punitive, persecutory superego that runs amok, self-denigrating and self-blaming. The depressive OCPD differs from the depressive narcissist in that the depressive narcissist turns his or her preoccupation with perfectionism

against the self, whereas the depressive obsessive-compulsive turns their perfectionist self against others by projecting their ego ideal onto them. Their preoccupation with perfectionism turns not only against the self but against others, projecting their ego ideal onto them.

> *Do you want to go to a movie? How about out to dinner? Can we stop at the market? You never want to go anywhere or do anything. You make everyone around you miserable. Even when we do go out to dinner, you make our dining experience impossible. You complain constantly about the food and keep returning it. And when you get the bill, you act like the restaurant is trying to cheat you.*

The Antisocial OCPD

Her obsession with money was more important than her husband and family.

The antisocial OCPD presents more superego pathology. The most pervasive features of this personality are the lack of superego functioning and the lack of capacity for guilt, remorse, and desire to make reparation. The obsessive-compulsive differs from the antisocial personality in that the antisocial OCPD wallows in their obsession, and their mission or "cause" defies concern about consequences or retribution. In fact, they even derive pleasure by getting away with such wrongdoings as scamming and taking advantage of others.

A good example of an antisocial OCPD is someone like Bernard Madoff, the businessman

who scammed thousands of trusting investors in a Ponzi scheme to fulfill his own grandiose fantasies and obsession with money. Without any pangs of conscience, he made everyone believe he was their "benevolent uncle." When he got caught and was arrested by the FBI, he showed no remorse. His obsession with money even went beyond his caring for his wife in that he set her up so that his actions were separate, and nothing he did would incriminate her.

The OCPD the Artist

The obsessive-compulsive narcissist has very little regard or empathy for others. To achieve any sort of empathy, the obsessive-compulsive narcissist must face the fear that he or she may not be perfect enough and learn to distinguish delusions from reality. As a defense

against ordinary human needs, the obsessive-compulsive will clean, wash, or check files repeatedly. This behavior, based on the need for perfection, can inflict fatal flaws in communication.

We must prepare to meet the challenges that face us daily in our consultation rooms. Writing about, researching, and studying narcissism, as well as being around dancers, musicians, and artists my entire life and living in Los Angeles, the epicenter of the entertainment industry, have made me aware of how artists live in their own world. My experience as a dancer and psychotherapist has given me further insights into the particular struggles they encounter and their ruthless need for perfectionism. Yet there is not a separate category for artists. How does the

obsessive-compulsive fall into the artistic world under the rubric of narcissism or other personality disorders? It is the obsessive-compulsive's perfectionist, ritualistic self, along with the corresponding components of entitlement, that qualify dancers, musicians, and artists to enter into the realm of the artistic.

> *What gives an OCPD director the right to keep his production on hold while he ruminates, checks, rechecks, and performs washing and cleansing rituals?*

While clinical narcissism connotes *pathology*, there are also "healthy" aspects that one might call "aesthetic survival." For the narcissist artist to forgo the narcissism that allows the pursuit of his art is tantamount to killing the artist. Healthy narcissism allows

room for grandiosity, pomposity, self-involvement, and an obsessive investment in perfectionism; yet there is realization of the need for healthy object relations. The same applies to the OCPD, who needs a certain level of perfectionism.

There is a sense that the artist needs some transitional space to experience his art (Lachkar, 2004, 2008a, 208b, 2013, 2014). Ironically, the artist may need a certain amount of narcissism, grandiosity, pomposity, or perfectionism to pursue their endeavors. The pathological artist is a true perfectionist and can never meet their own expectations. Some of the major concerns of the artist are depression, trauma, insecurities, and relentless rumination as to *"Why didn't I get the gig?" "What is wrong with me that I wasn't*

chosen at the audition?" "Why have so many publishers turned down my book manuscript?" Many artists have committed suicide or gone into deep depression; Van Gogh and Leo Tolstoy, among others, are examples of those who had unattainably high standards, with Ernest Hemingway another example of an artist who suffered severe depression and anxiety and who, sadly, took his own life. The path of the artist takes a different route than, say, that of a teacher. The teacher graduates and gets a position. The artist can create a work of genius and not get any response.

So where do we draw the line on how much is art and how much is pathology? The healthy OCPD can be obsessed ("aesthetic survival") yet still tries not to let his art interfere with the

ability to have healthy object relations. The pathological artist is the one who functions at the extreme end of the narcissistic spectrum, and their art does indeed interfere and obstruct the ability to maintain healthy relationships.

> *It is okay for us to be weird and not allow such things as envy, competition, and oedipal rivalry to get in our way.*

In fact, these are precisely the elements that can destroy creativity. The main objective is to help the artist maintain healthy object relations while staying on their journey.

Many artists resist therapy amid fear that therapy will make them normal. Thus, the real challenge for the therapist is to help the artist with awareness that when primitive defenses such as shame, blame, envy, domination,

omnipotence take over, they get in the way of creativity.

Another area of therapeutic challenge is creating awareness among artists that their partners are frequently not getting the financial or psychic support they need. This is especially true of the successful artists whose acclaim makes it difficult to provide the necessary level of empathy and support needed by partners and families.

The OCPD Cross-Cultural Couple

Dealing with cross-cultural couples runs the risk of making wild generalizations and stereotyping. OCPD cross-cultural couples present a real challenge. I can only speak from my clinical experience, my research, and work as a psychohistorian. I would like to make a

disclaimer that not all people from diverse backgrounds adhere to the same cultural traditions and ideologies or what I refer to as "collective group myths" (Lachkar 1992, 2002, 2004, 2008a, 208b, 2013, 2014, 2020). Chapter 6 provides a more in-depth approach to cross-culturalism and addresses the attendant societal and cultural issues

The following is an example of a cultural OCPD and his newly married wife.

> *An Israeli man married to an Irish Catholic woman insists that she convert to Judaism without any consideration of what is important to her or her family. He becomes obsessed and demands that she go to temple every Friday, buys her Jewish cookbooks, takes her only to Kosher restaurants, and refuses to eat the non-Kosher foods she enjoys. Although it could be said*

that the husband is entitled to respect and honor his religion, he is not entitled to force his beliefs upon his wife. One also could wonder why he failed to recognize this before marriage. As mentioned earlier, among many people with primitive defenses, the ego goes into dysfunctionality and, as a consequence, their behavior is not on their emotional radar screen.

This brings about another challenge: How do we find pathology? Where do pathology and culture meet? To address this issue, I originated the concept of the "cross-cultural hook"—that is, to find pathology via some contradiction. In the case above, one could address the biblical teachings that urge showing respect for one's' wife; for example: "As a man of G-d you must respect her opinion, show interest in her projects or passions" (Peter 3:7).

Summary

Extrapolating from my earlier publications on the dynamics of many narcissistic/borderline relations, I ventured to explore other kinds of relationships. With the pandemic, my focus shifted to the obsessive-compulsive/histrionic relationship. This chapter aimed to point out their qualitative distinctions by describing the different kinds of OCPDs, many of whom share the common-denominator traits of control, perfectionism, domination, and attachment to objects (unlike greater concern with specialness and what other people think). Although communicating with an OCPD is not an easy task, having the recognition of what triggers their "V-spot," can help foster communication. Whether it be the artist or the cross-cultural obsessive-compulsive that is involved, this

awareness of V-spot triggers is beneficial not only for the therapists treating these clients but also for the partners who love and live with them.

Part Two
Treatment Approaches

Chapter Three

Therapeutic Functions in Couple Therapy

This chapter contains the "nuts and bolts" of the therapeutic technique for couples. It is a recapitulation of and reflection on various concepts expanded over many years. Here, the focus is not on "diagnosis" but primarily on the psychodynamics within the context of the relational dyad.

The ground rules of couple therapy is basically the same as those for individual therapy, except if one partner decides to have an individual session or contacts the therapist out of session, the therapist still works under the

umbrella of couple therapy, where information can be shared. However, this is up to the discretion of the therapist.

Couple therapy is a performance, and we are all actors in this performance

Couple therapy provides an in-depth approach to working through couple conflicts and disagreements. It considers such matters as family conflict, childhood trauma, and attachment disorders. Couple therapy is an experience that occurs among three persons. I coined the term "couple transference" (Lachkar, 2008a, 2008b, 2014a, 2014b) to show how the couple projects onto the therapist. The deeply emotional experience of intense communication and feelings that therapy entails begins with acknowledging the profound challenges of a primitive relationship and matures into the

awareness of healthy dependency needs and mutual respect. The couple presents its own dramatic narrative, and with each session the curtain opens on the opportunity to create a new experience. Many of the suggestions or "advice" we give is subjective; we do not abide by a group of laws. You can't say, for instance, "There is a law that says you must take your wife out for Valentine's Day and buy her flowers!" The experience is more subjective, and the needs of the couple gradually unfold as therapy continues. Couple therapy can be long or short term and is determined as the process unfolds. Timing and the way the therapist deal with the patient can be highly sensitive issues.

Therapeutic Techniques

In many of my earlier works (Lachkar, 1992, 2004, 2008a, 2008b, 2014), I stressed how important it is that psychoanalytic technique be executed artistically, emotionally, empathically, and creatively; otherwise, therapy becomes shallow and lacks depth. Just as the artist, the musician, the dancer has to learn their specialized techniques well, so does the therapist. As therapists, we have much to learn from great artists. Each thoughtful word, intervention, or interpretation—like a stroke of a paintbrush—must be expressed with meaning and purpose. Otherwise, it becomes robotic. Eye contact, the tone of voice, phrasing, and timing are attributes that enhance the process. This is not intended to make the therapist "perfect";

rather, it is more about providing a safe, expansive environment in which to work. The therapy session is like a "performance" and must be convincing enough to hold the patients' interest and to open up space for a new emotional experience.

The particularly inspiring late violin virtuoso, Isaac Stern, claimed that a musician must embody three qualities—confidence, musicality, and enough arrogance to carry it off. Drawing from Stern's words, I have abstracted five qualities a therapist should exhibit: (1) confidence, (2) empathic attunement, (3) containment, (4) precision, and (5) authority, which is not to be confused with control. Of course, there are many more things involved, including timing, focus, and the ability to move

through the transitional space to a new awareness that contributes to the success of the therapeutic session. At the start of each session, I always think of a conductor going up to the orchestra podium and stating, "Let's not waste time; let's start right in!"

The Initial Session

Welcome! The session is 45 to 50 minutes. We will begin by each one of you presenting what your individual issues are. Speak freely. When one speaks, the other listens, and vice versa. We will then interact for a while, after which I will do my best to give you an evaluation and some treatment suggestions. Okay who would like to start?

You start! No, you start! No, you start!

Already in this scenario the therapist has a sense of enmeshment, which is quite common in the first phase of treatment. I divide sessions into three parts (also see three phases of treatment later in this chapter).

Welcome

The first part is the welcome and begins with each partner presenting their specific issues.

Interactive

The second part is interactive. The therapist intervenes.

- This is not a tennis match or a competition!"
- What you call a complaint I call a need (time, love, attention).
- Feeling vulnerable is the healthy part of you.
- Look, he does the same with you he does with me! (therapist gets invited into the couple

transference.

- You get triggered whenever your sense of specialness is being threatened, and you get triggered whenever your sense of existence is being threatened.
- He projects shame onto you, while you project guilt.
- When you attack, he withdraws. The more he withdraws, the more you nag!

Reflective

The third part is reflective (remorse reparation, sadness). Reflecting back to areas of hurt and identifying triggers to the V-spot. This is a time for introspection and coming to terms with past transgressions.

Closing of session

The therapist requests that each partner relates what was most meaningful to them in the

session.

> *I like when I experienced how he does the same with you that he does with me.*
>
> *I realized that she has needs, but it is her outbursts and her needs that make me crazy.*

The therapist should recap the dynamics at the end of each session and stay aware of the qualitative differences between the partners. Rather than saying, "You both feel betrayed, you both feel abandoned, and you both feel anxious," show you are aware of the differences brought out in the session: "You (A) feel anxious whenever your sense of specialness is threatened, and you (B) feel anxious whenever you feel a threat of abandonment or betrayal.

Essential Concepts

The therapeutic techniques presented in this chapter are an integration of many concepts that morph into one another, including the V-spot, the languages of empathology and dialectics, listening for a theme, and the attachment to good/bad objects.

The V-Spot

The V-Spot is the term I created to describe the epicenter of one's most vulnerable area of emotional sensitivity that unwittingly gets aroused when one's partner hits a sensitive chord. This area, known in the literature as the "archaic injury" or the "narcissistic injury," is described by Heinz Kohut in his work on self-psychology (1975, 1977). Originally, I applied the term to those with narcissistic personality

disorder (Lachkar, 2004, 2008) to delineate the emotional volatility that erupts when this early childhood injury is aggravated by a situation or a remark. I found the term V-spot more user friendly, catchier, and simply more accessible for patients and people in general. "He/she really stirred up my V-spot!" is more comprehensible to the average person than referring to "vulnerability stemming from the archaic injury." The V-spot is not confined only to patients; everyone has a V-spot, an area of intense vulnerability that can precipitate a disproportionate emotional response.

Does each disorder have its own V-Spot, its own specific area of vulnerability? Yes, I believe each disorder does. The narcissist gets triggered when their sense of specialness or entitlement

becomes threatened. And the borderline gets triggered when their sense of betrayal or abandonment is stirred up. When injured, the narcissist will withdraw—as opposed to the borderline, who will attack or go into a borderline rage. The OCD gets triggered whenever their sense of perfectionism or rituals against contamination are threatened. The OCPD could care less about appreciation but is more concerned with fear of intimacy, emotional contamination, and losing control when getting too close.

> *Don't talk about my weight, don't talk about my mother, and don't talk to me about politics.*

At the least provocation, the V-spot blows when the individuals' buttons are pushed. As soon as things get shaken, everything shifts—

including memory, perception, and, most important, reality and judgment. The dysfunctionality of the ego helps us understand why people say and do stupid things and highlights the patient's distortions, delusions, and misperceptions. What makes an anorexic think he/she is fat? What makes a shopaholic think they can afford to buy the things they can't? What makes a person with no talent, or a "wannabe," think that they will become rich and famous? What makes narcissists think they are entitled to things they're not, or makes the borderline believe that acting the role of the victim will bring love or self-esteem? What makes an obsessive–compulsive think that cleaning up will become the replacement for the desire for intimacy?

The Ego and its Functionality

The V-spot is inextricably linked to the ego apparatus and its capacity to think and function (Lachkar, 2008). Even the most well-seasoned mental health professionals can lose sight of how early trauma impacts ego function and contaminates the power of reason and judgment. Throughout this book, references are made to those with obsessive-compulsive disorders who remain forever attached and dedicated to early archaic injuries, or V-spots, to bad internal objects and the "mother of pain. While these defenses are operative and there is so much anger and confusion, it is not the time to get a divorce or make other major life-altering decisions.

When the V-spot is ignited, the first thing to go is the ego; judgment, memory, perception, reality testing, impulse control, tolerance, and ego identity are lost. This is particularly notable in obsessives, who become so riddled with anxiety to avoid mishaps and failures that many times they are not able to make rational choices.

The ego is an amazing apparatus, but it is not user friendly in that it resists what it "knows." Everyone has a grasp of what the ego is, but it is also a slippery concept. Although many authors offer accounts of "ego weakness" or "ego fragmentation," no one says it better than Otto Kernberg (1992). The ego is the superior agent responsible for memory, thinking, judgment, attention, perception, and the capacity for reality testing. Kernberg loves reality. The function of

the ego is to see the world by eliminating old memory traces left by unresolved early childhood conflicts or traumatic experiences. It is the capacity to discern the real from the not-real. It is the mediating agent that provides entrée to the unconscious.

The ego is akin to a computer, with its own data bank and a spyware program to warn of the danger signs (like a virus). As painful as it is to face the most non-faceable, doing so is the very essence of inner aliveness.

> *Even though my conflicts are difficult, when I face them head-on I suddenly feel a sense of aliveness!*

The Language of Empathology and the Language of Dialectics

Originally these "languages" were designed for narcissistic and borderline personalities.

More recently, however, they have shown their applicability not only within a clinical setting but in interpersonal relations as well (e.g., dealing with a disgruntled neighbor). Here I draw from many theoretical perspectives, mainly classical psychoanalysis, self-psychology, object relations, and attachment theorists.

I initially abstracted the Language of Empathology from self-psychology in the works of Heinz Kohut (1971) to meet the mirroring and self-object needs of the narcissist. The Language of Dialectics, on the other hand, I designed to meet the splitting needs of the borderline. It is based on object relations, including the work of Wilfred Bion (1961), James Grotstein 1981), Melanie Klein (1957), Kernberg (1992,) and, of course, Marsha Linehan (1993), who is well

known for her work on Dialectical Behavioral Therapy (DBT). I now find these "languages" suitable not only for narcissistic and borderline disorders but also for dealing with other personality disorders, as well as for many patients in general clinical practice. They also are useful for stimulating effective conversation in personal relationships.

Throughout this text and in the cases presented, these two communication styles show their special applicability for the obsessive-compulsive.

Language of Empathology

> *It is amazing that a man of your stature, a brilliant scientist and someone world renowned who receives recognition from the most prestigious universities would give your partner so*

much power. Yes, her histrionic outbursts do remind you of your mother. But there is a difference. When you were a little boy, you were helpless, but now as a grown man you are not powerless.

A beautiful woman comes every week to see me, dressed to the nines, using the excuse that she is low on money and cannot afford to pay her therapy bills. Yet she wears the finest of designer clothes. What I really wanted to say to her was, "It seems strange that you can't afford treatment when every week I see you with new jewels and beautiful clothes!" Instead, I said, "How lovely you look in your new clothes. I can see that how you look is more important than your mental health!" The patient responds positively, although she might have responded, "Are you insinuating I shouldn't spend my money on clothes?" To that, I would have answered,"

Granted, the clothes are beautiful, but they are not lasting. Treatment will help you forever to grow and develop."

Yes, you recognize there is a safe and practical side to your hoarding that makes you feel safe when you are surrounded by objects. But the other side of you feels lonely and isolated.

Language of Dialectics

The Language of Dialectics addresses shame/blame attacking defenses (splitting).

A man comes in desperately seeking advice. "What should I do? Should I stay married or get a divorce? I hate my wife, I want a divorce!"

To Be Here or Not to Be Here: Case of Mr. and Mrs. V

The case below is an example of the language of dialectics, which addresses the splitting and

ambivalence of the borderline patient. Splitting is very much in concert with Marsha Linehan's formulation of Dialectic Behavioral Therapy (1993).

Mr. V: I want out of this marriage.

Th: Then why are you here?

Mr. V: I don't want to be here.

Th: But you are here.

Mr. V: I want to know what to do. But I think I want out. She is no longer a wife. She doesn't cook, go out with me socially, and she is very withdrawn from me.

Th: Oh!

Mrs. V: I am withdrawn because he has a terrible temper. He always yells at me and attacks me over the littlest thing.

Th: So you get scared.

Mrs. V: Scared? I get terrified! My parents used to yell, scream at me, and even pull my hair.

Th: Does your husband physically attack you?

Mrs. V: No, he just gets angry and very controlling.

Th: (to Mr. V.) I hear your wife saying she is very afraid of you.

Mr. V: Yes, I know, and that is why we are here.

Th: So you are willing to work on controlling your anger?

Mr. V: Yes, but I don't know how. When I was growing up and living at home, everyone in my family would fight, so I never learned.

Th: Yet you say in your business as a contractor you show control and patience with your customers, and that's a tough job.

Mr. V: Yes, people get very emotional when it comes to their homes, but I manage to keep my cool.

Th: So it shows you have the capacity to control your emotions.

Mr. V: Yes, but that is different. When I come home I just want to relax and be myself.

Mrs. V: Yes, being yourself means taking out all your stress on me!

Th: Well, if you can do it with your customers, you can do it at home. Your wife is just as important as your customers.

Mr. V: Hmm. I think you're right. I do love my wife and want things to work out.

Mrs. V: But I'm not happy.

Mr. V: Neither am I.

Th: What I am about to say may sound strange to you, but for now the focus should not be on "happiness." I want you both to "function" as a couple. To stay in your "roles" as husband and wife (just as when you are a contractor you play your role or I play mine as a therapist).

Mrs. V: I don't want to do that. It sounds phony.

Th: I can understand how it sounds phony, but what you are doing is phonier, withdrawing and wishing you were somewhere else. So what choice do you have?

Mrs. V: (smiles for the first time as if there is a glimmer of hope). Yes, I will try, and because my daughter has an eating disorder, I will do it for her.

Th: Sounds good. See you both next week.

Mr. V: Thank you, doctor.

Discussion

Listen to the Words of the Internal Object.

> *Get a divorce?! You are "divorced" from yourself!*

This case addresses the splitting, and the ambivalence and confusion of a pathological relationship where primitive defenses such as rivalry, competition, envy, control, domination dominate. Here there are two Mr. Vs, one that wants to stay married and the other that wants a divorce. When V-spots are flying ego goes into dysfunctionality. "These two parts of you are in constant battle, which means that this is not a good time to make major life decisions." Note how the therapist tries to wean the couple away

from a focus on "happiness" and to replace it with the idea of "functioning."

Treatment Phases in Couple Therapy

Melanie Klein described two treatment phases (the paranoid-schizoid and the depressive position), designed to show how individuals move from one phase of development to the next. However, in treatment with couples something a missing. So I added a third phase, a transitional phase that serves as an entrée to the opening of awareness (Lachkar, 1992, 2004, 2008a, 2014).

Phase One: The Phase of Darkness, A State of Oneness (Fusion/Collusion)

Phase Two: A State of Enlistment, a State of Twoness (Transitional Space)

Phase Three: A State of Reason, Awareness of Two Emerging Separate Mental States (Dependent and Interdependent)

During the initial phase of treatment, the couple lives psychically "inside" the emotional space of the other. It is a state of "oneness," fusion/collusion. It is a shame/blame phase, with each one blaming the other for all the shortcomings in the relationship (who is right, who is wrong, finding fault, getting even, and retaliation). There is much stonewalling, blaming, and shaming. Each partner shows little awareness of the inner forces that invade the psyche. Instead, there is a preponderance of primitive defenses such as splitting, projection, and projective identification.

The second phase marks the emergence of "twoness," a glimmer of awareness of two separate emotional states, a sense that the therapist can be useful. There is more tolerance

for ambiguity, budding insights into unconscious motivations (internal objects), the ability to see the therapist as someone who is helpful and not the enemy, a beginning of bonding with the therapist and a "weaning" away from living emotionally "inside" the object toward mutual interdependence.

This third phase ushers in the beginning of the depressive position, the ability and willingness to feel sad and express remorse. This is the phase in which reparation occurs, the desire to "repair" the damage, to embrace guilt, mourn, and take responsibility for past transgressions. It is a time when each partner comes to terms with uncertainly, ambiguity, and healthy dependency needs. It is a time to heal and listen non-defensively to one another's hurts

as well as see the diminishment of repetitive negative projections.

Therapeutic Functions

Therapeutic functions constitute a major part of the skills and techniques used by the therapist. I am reminded of a therapist in one of my supervision groups who expressed guilt that she was charging full fee for a patient to whom she felt she was not contributing enough. But unknowingly she was providing an important therapeutic function—listening, which is among the essential therapeutic functions that help make meaning out of the meaninglessness. These functions include:

- Empathy
- Listening
- Clarity

- Introspection
- Mirroring
- Containment
- Therapist as self/mirroring object
- Therapist as the container
- Therapist as the transitional object
- Therapist as the holding/environmental object
- Therapist as the provider of meaning
- Sense of humor

In addition to the essential techniques that the therapist must cultivate, there is also a roster of important therapeutic tools that are available to the therapist. Included in this familiar armamentarium are:

- Transference
- Countertransference
- Couple Transference

- Splitting
- Psychodynamics of the Couple
- Projective Identification
- Dual Projective Identification
- The Bad Breast/Good Breast
- Schizoid Position
- The Depressive Position
- Reverse Superego
- Language of Empathology
- Language of Dialectics

The Psychodynamics of the Couple

Just as there is a "dance" between the couples, between the theorists there is also a dance between their psychodynamics

There is not only a "dance" between the couple; there is also a dance between their

psychodynamics—affair/ shame, envy/ jealousy, domination/ control, attachment/ detachment, submission/ victimization, omnipotence/ dependency, among others. What follows are some very common ones. The others are detailed in many of my other publications and contributions.

- Shame vs. Guilt
- Envy vs. Jealousy
- Domination vs Submission
- Omnipotence vs Dependency
- Projection and Projective Identification
- Control/Domination/Victimization
- Competition/Rivalry (Oedipal conflicts)
- Cross-Cultural Psychodynamics

Shame and Guilt

Shame is a matter between self and others (family, community), whereas guilt is a higher form of development and is a matter between the individual and his conscience. The latter has a moral component, a superego or voice that judges between right or wrong. Shame is persecutory in nature and is a defense against the humiliation of having needs that are felt to be dangerous and threatening. Shame is associated with anticipatory anxiety and annihilation fantasies.

> *I have such shame telling my boyfriend what I really need, for fear he will abandon me.*
>
> *I feel guilty she caught me having affairs, and I feel guilty for having betrayed her.*

Envy versus Jealousy

Envy is destructive and seeks to annihilate that which is enviable to destroy what the other person has. Jealousy is the desire to have what the other has but does not seek to destroy.

> *When I first met her she had beautiful breasts. Now I want to destroy any man that looks at her.*

Projection and Projective Identification

Whereas projective identification is a one-way process, dual projective identification is a two-way process that lends itself to conjoint treatment. One partner projects a negative feeling onto the other, who then identifies or over-identifies with the negativity being projected. Referenced also is the term dual projective identification to illustrate the dance the movements go back and forth.

I'm not stupid! Don't call me stupid!

Dependency vs. Omnipotence

Omnipotence and grandiosity become the defense and replacement for healthy dependency needs. Dependency often get distorted as it equates with weakness and vulnerability.

Control/Domination/Victimization

Very common dynamics in couples therapy and are covert. Many don't see victimization as a means to control and dominate but it is often not recognized as a form of aggression e.g., silence, excessive sobbing histrionic outbursts

Competition /Rivalry (Oedipal Conflict)

Fantasy that there is reciprocity all things equal in reality does not exist. Many couples get into a "tit for tat." 'You did it to me then why

can't I do it to you!' Often will fight to the bitter end to they are treating fairly. Goal is to help moving about from competition to facing the needs of the couples. Moving away to competitive rivals to love and healthy dependency.

Six Treatment Steps

- The therapist must see the couple together before transition into individual therapy (to form a safe bond). To move into individual work too early can induce a "rapprochement crisis."
- Be aware that couple interaction can diminish individuality.
- Therapeutic alliance must be joined with the partner who is predominantly narcissistic because of their tendency to flight/flee, isolate, and withdraw, which can pose a serious threat to treatment.
- Be aware that the more primitive the couple, the more structure, simplicity, and clarity they need.

- Inform the partners about confidentially, that if seen separately guidelines of confidentiality still pertain; however, the therapist has the right to use discretion about what to share.

- Recap the dynamics at end of each session; ask what was most meaningful.

  Avoid: "You both feel betrayed, you both feel abandoned, and you both feel anxious."

  Prefer: "You (N) feel anxious whenever your sense of specialness is threatened, and you (B) feel anxious when feeling abandoned or betrayed.

Suggestions for the therapist:

- Don't be afraid to confront the aggression. Speak directly to the aggression with technical neutrality by making clear, definitive statements. Be empathic toward the pain and the patient's vulnerabilities but avoid getting drawn into the couple's battle.

- Maintain eye contact throughout the session to enhance communication and engagement.

- Do not talk too much. Listen and be attentive. Speak with meaning and conviction. Talk directly to the issues.

- Be aware of the separate issues of the partners (*you feel shame; you feel guilt*).

- Summarize the session.

- Ask each participant what was meaningful to them.

- Continually reevaluate the treatment goals (remembering why the partners sought your help in the first place!).

- Avoid asking too many questions and spending time obtaining lengthy histories during the first session. Don't waste time. Start right in. The history and background information will automatically unfold within the context of the therapeutic experience and the transference.

- Avoid self-disclosure, touching or consoling the patient, being unyielding or making concessions.

- Use short, clear sentences and keep responses direct; mirror and reflect sentiments with simple

responses and few questions.

- Keep in mind the concept of a "normal couple" or "ideal couple." This image will sharpen your focus and will safeguard you from getting lost within the couple's psychological "dance."

- Explain how one may project a negative feeling into the other, but try and see how the other tends to identify with what is being projected (focus on the dual projective identification).

- Listen for the theme. Be aware of repetitive themes. While the subject and feelings may change, the theme is pervasive (betrayal, abandonment, rejection fantasies).

- Help the couple recognize "normal" and healthy dependency needs.

Suggestions for the couple:

- Learn to listen in a new way to the complaints of your partner.

- Don't attack, retaliate, or get into the battle.

- Wait for a quiet time to engage in discussion and be sure to follow through.

- Don't leave the room mad. If the atmosphere gets too "heated," reassure your partner that you will return in a short time when he/she calms down; do it and mean it.

- Stay differentiated; don't get hooked into the deception or the manipulation.

- Trust that you have been manipulated and deceived; don't question it.

- Don't wait for the "right time;" it is never the right time!

- If your partner is a narcissist, be sure to address issues his strengths, good attributes, and what you appreciate about him; gradually let him know what he does that is hurtful to you. Don't attack show you understand, but don't give up your own needs.

- Recognize the difference between venting and evacuating as opposed to serious thought.

  "Honey, you don't really mean I'm a fucking bitch; you're just upset with me!"

Common Complaints That Bring Couples into Therapy

With all her piety and rational thought, she does not hear a word of what I'm saying!

Now that we have all these various listening approaches, what is it we listen to? Most complaints on the surface seem to revolve around children, sex, money, commitment, work, and outside intrusions (ex-spouses, in-laws, friends, sports, pets, hobbies). But the underlying issues are more about control, domination, envy, jealousy, shame, guilt, submission, victimization, and oedipal rivals.

Many couples come into treatment confused and baffled. The female complains, "He pays more attention to his dog than to me. All my husband cares about is when he can play golf.

When he's not playing golf, all he does is work, work, work. He doesn't spend time with me or the family." The male grouses that "All she cares about is getting her acting career on track."

The discussion that follows contains some typical examples of issues that bring couples into treatment. Neglecting to address these issues brings about a lack of trust and failure to provide a safe and reliable holding environment. One of my daughters, who is a clinical psychologist, said, “Mom, you’re making this more complicated than it is. It is about sex, money and kids; that’s it!”

After couples in therapy learn how to communicate with each other, what do they communicate about? Almost every therapist could come up with the same reply: complaints!

The Merriam Webster Dictionary defines a complaint as a means to express grief, pain, dissatisfaction, or discomfort. A complaint also could involve a formal accusation or charge.

> *If you are unhappy with the service, complain to the manager. If you are unhappy with this culture, go back to your own country.*

Synonyms for complaining include: to crab, fuss, gripe, moan, nag, wail, whine, grumble. In more simple terms to complain is "to kvetch!"

Mrs. N complains that her obsessive-compulsive husband is withholding, cheap, refuses to spend money on her. He complains that she is a nag, a user, and keeps insisting they need to go on vacation. As time goes on, the OCD husband begins to reenact the same drama with the therapist. He begins to project his anal

self by making the therapist feel guilty when asking for payment, refuses to come to sessions on time and to meet the therapeutic commitments. Suddenly I become the demanding doctor, one who takes all his money and his time. Now I am "the nag!" Mrs. N then starts to feel some relief, "Hey, it isn't all about me; he does the same thing with you!" But it doesn't stop there. As she continues to tell us how withholding he is with money, she also complains that he pulls away whenever she tries to get intimate. "So, Mrs. N, you think you are complaining that your husband withholds money, but he also is withholding from himself by withholding his own needs for closeness, intimacy, and emotionality.

Mr. N says, “My wife thinks I am a withholding asshole. I am under constant surveillance. Everything I do gets criticized. I am constantly under attack and suffering. It’s nag, nag, nag—day and night. All my wife thinks about is going on vacation when we have a perfectly fine back yard that she enjoys. She conveniently forgets that I already took her on a vacation. I am a good breadwinner, a good provider. But that isn’t enough for her. Then she complains about our intimacy. She knows I don’t like to be touched, but she does it anyway; then when she doesn’t get what she wants, she begins to cry and get all emotional. She knows I don’t like all that drama.”

I refer to the language of empathology to interpret to Mr. N that there is a part of him that

desires to have an intimate relationship; however, there is an intrusive voice of a father that persecutes and halts him from engaging in the type of relationship that being intimate requires. I refer to the language of dialectics to interpret to Mrs. N that two parts of him have split. At this point I use couple transference and show how through projective identification he transfers his "anal" self to me. I tell him, "So now I become the nagging, demanding mother! Yet I don't ask you to take me shopping, take me on vacation, or demand intimacy."

When Is a Nag a Nag and When Is It Not a Nag!

I'd rather be hit by lightning than listen to her nagging!"

When is a complaint a legitimate complaint, and when is it used for evacuation?

When it comes to listening to patient's complaints, the road is endless. It is challenging enough to "listen" to our patients who share the same background and traditions, let alone our cross-cultural patients. The latter requires not a third ear, as Theodore Reik (1948) maintained, but a fourth one. Inspired by his work, I have expanded on well-known analyst's Salman Akhtar's listening techniques. While Akhtar's book *Psychoanalytic Listening* (2013) does not specifically reference patient's complaints, his listening techniques have profound application to this subject. He goes beyond "'the talking cure" to the "listening cure," based on the premise that listening with no talking or talking with no listening can only go so far. He believes the analytic community has been short-sighted about the importance of listening. What follows

are complaints that I will classify as “third- ear” listening.

Different Ways to Listen

My mother abused me!

Objective Listening:

Listening to the patient and taking his/her words at face value. The detached observer, one who listens without preconceptions, abandons all conscious memory. Self-psychology takes the position that the patient’s reality is the “truth." It does not consider the patient’s reality as delusional or distorted. In object relations, the patient’s “distortions” and misperceptions” are considered as part object functioning, split off and projected.

Subjective Listening:

Wondering what the child did to make the mother so angry. Paying attention to the therapist's own reactions, countertransference, body movements, (toe tapping, wiggling, sleepiness) as he or she responds through bodily empathy.

Empathic Listening:

To feel what the patient feels by getting a taste of his experience through mirroring and empathic understanding to begin to understand why the patient feels that way. This empathic understanding is what Kohut refers to as empathic immersion.

> *I can understand how traumatic this must have been for you.*

Introspective Listening:

This valuable listening technique offers the opportunity to reflect on how the patient's traumatic childhood/experiences impact current relationships. Theodore Reik's (1939) innovative work, *Listening with the Third Ear,*accesses the unconscious by recognizing its intuitive messages.

Let's take a look at how this abuse impacts your life.

Intersubjective Listening:

When two subjective realities come together in a collaborative effort to attain the final immersion. This is the point when two parts of the unconscious meet and understanding occurs. In couple therapy this can be most valuable.

There is something you do that makes people angry with you, but even so no one has the right to abuse you.

Transference and Countertransference Listening:

Therapist gets annoyed with the patient. "When I told you about the increase in the fee, I knew you were not complaining about money. It is more about the feeling that I am going to be like your mother and abuse and take advantage of you. You have accumulated much wealth and now you feel people take advantage of you." (Meanwhile the therapist is struggling with his/her own financial issues.)

Listening to the Silence and Non-Verbal Clues:

Picking up the non-verbal communication (unmentalized experience). Therapist gets extremely tired in session. The patient

continually yawns, talking in long slow, excruciatingly drawn-out sentences, to the extent his analyst could hardly keep his eyelids open. The therapist finally interpreted what was going on and gave his insights to the patient: “You are letting us know what it feels like to have an empty, internal world where there is nothing going on."

Internal/External Reality:

Listening to the words in an analytic session is like reading poetry. Often, the words are the metaphor for the entire session or the thematic motif.

There was a lot of traffic coming here. I also forgot my check book.

So, doc, you’re saying that it is not about the traffic but my internal traffic

that gets in the way? Hmm, I never thought about it that way.

Case of Mr. A:

He is a highly trained a computer scientist. His area of expertise is to attack viruses. He has difficulty confronting his wife about her inability to be intimate. He complains she does not like to be touched and refuses to give him a blow job. She thinks penises are dirty. He complains she is toxic, yet he doesn't have the nerve to confront her. Using the language of empathology, I show admiration and respect for him as a computer specialist and how he has not had trouble confronting the computer, yet his relationship has a virus. >*Maybe you don't have the words to confront her "virus"!*

Case of Mrs. B:

A CEO of a company complains her husband cheated on her and says she has withdrawn sex and that he blames her for his transgression. Mrs. B says, "He complains that I do not French kiss, don't engage in oral sex, and have isolated friends and family." The therapist uses the language of dialectics to respond. "This in no way justifies your husband's betrayal, but we also need to look at how you betray yourself. There's one side of yourself that feels "cheated" by your husband, but the other side is how you cheat yourself. Yes, there can be external cheaters, but there also can be an "internal" cheater that cheats on you and holds you back from enjoying your life."

Case of Mrs. C:

Using the language of empathology, I validate her as an accomplished actress and how someone with her talent loses contact with the role in her "script" and becomes her "sickening" internal mother. "It is hard to stay in contact with the part you play when suddenly the voice of your 'sickening' mother appears! You not only identify with this sickening mother, you actually 'become' her; this causes you not only to lose contact with your role but also to lose contact with who you are in reality. So, you need to cleanse yourself to rid yourself of her."

Summary

Communicating with an obsessive-compulsive narcissist is difficult. They often ramble on, taking forever to say what they want

to say. Even after they have said it, they claim you have not heard them and will repeat the entire monologue over again. When we do offer our advice, it is often met with boredom or with comments like, "That is nothing new; I have read about that, know all about it," and claim that the therapist doesn't have a clue about what is going on. To this the therapist might respond, "Of course you know it all, have seen it all, read it all. I'm sure for a man with your background and knowledge, this holds true. However, what you are missing is the human experience and the contact. So after you know it all and have it all, you can go back to your books, your files, wash me away in your sink, using your sterile soap. But then you have lost out on having an intimate experience, something you originally came in craving to have."

As in many of my other publications this chapter ranges from many theoretical perspectives and offers many varying approaches. Although different in styles, methodology and techniques, this chapter attempts to apply some fundamental guidelines for therapists treating couples (and individuals). These include basic therapeutic functions such as the V-spot, two languages, listening, couple transference and other methods not only suitable for OCPD's but other personality disorders as well. It is challenging to communicate with an obsessive-compulsive to listen to them. To discern when a complaint is a complaint of when it is a legitimate need. Moving from the various types of listening styles, the therapist has an opportunity to "listen" beyond the words. The two "special" languages—the Language of

Empathology and the Language of Dialectics—which were originally intended for narcissistic/borderline personalities—offer specialized tools to hear the covert and decode messages. The V-spot is a tool to help spot the exact area of anxiety that gets triggered. Although the focus is on the OCPD, the two "special" languages and the V-spot have applicability in noting the qualitative and quantitative distinctions that characterize other disorders as well.

Chapter Four

The Theorists and Their Theoretical Perspectives

Different theorists have discussed various personality disorders. Even the most seasoned clinicians get confused when it comes to integrations of various theoretical perspectives. When we talk about an OCD whose OCD are we talking about? A Kernbergian OCD? Whose narcissist are we talking about? A Freudian narcissist? A Kohutian narcissist? Whose borderline are we talking about? A Kleinian borderline?

We now move to the theoretical, beginning with Freud's classical psychoanalysis, followed

by object relations, self-psychology, attachment theory, dialectic behavioral therapy, mentalization, group psychology, and a little pop psychology. The theoretical is important because when we talk about various personalities, it gets very confusing. Whose narcissists? Whose borderline? Whose obsessive? Freudian, Kleinian, Kohutian, Kernbergian? Although this is an integrative approach, I focus mainly on Klein's concepts. Her approach is dynamic, which helps us understand not only the movement between the couples but also between their psychodynamics (the dance between guilt/shame, envy/jealousy). Another valuable contribution comes from Fairbairn, who helps us understand how couples bond with painful bad internal objects (the rejecting/unavailable). Also included are such contributors as Heinz

Hartman, W.R.D. Fairbairn, Donald Winnicott, and John Bowlby.

Our Founding Fathers

This chapter was inspired by a colleague asking if different personality disorders are inclined toward more suitable theoretical perspectives and if each personality disorder has a proclivity toward specific dynamics. Do narcissists adhere better to Kohut's concept of self-psychology to meet their self-object needs? Are they more prone to shame or guilt? Are borderlines more prone to Klein's concept of object relations to meet their projections, distortion, splitting, and shame? Where does the OCPD fit? Because of their repudiation of emotionality, I would say that the OCPD takes an object relationship approach to address the split-off part of the self.

John Bowlby's (1969) theory of attachment addresses severe bonding disruptions and detachment emanating from early childhood. Notably, he makes the distinction between withdrawal and detachment. The narcissist tends to withdraw, whereas the OCPD tends to detach. Both the narcissist and the OCPD experience guilt but in different ways. The narcissist will feel guilty when they don't feel special. "What did I do wrong?!" Whereas the OCPD will split off guilt feelings then act out by depriving self and others.

Sigmund Freud: classical psychoanalysis (intrapsychic approach)

Heinz Kohut: self-psychology, mirroring, empathy, self-objects

Melanie Klein: object relations (focus on the internal, patients, distortions, projections, introjections)

W. R. D. Fairbairn: attachments to bad internal objects

W. D. Winnicott: transitional objects, different kinds of mothering experiences, (environmental/background/holding mother)

Otto Kernberg: aggression, drive/defense, and four different kinds of relationships

Wilfred Bion: therapist as the thinker, container, detoxifying mother

John Bowlby: attachment theory

Salman Akhtar: How to Listen

Sigmund Freud

Although Sigmund Freud (1957) did not specifically focus on marital therapy or emphasize communication, he was one of the first to bring attention to the obsessive-compulsive. This disorder was first termed obsessive neurosis, or what his colleagues would refer to as "irresistible thoughts." Freud's first

conflict was internal, between the id, ego, and superego; the focus was on the intrapsychic rather than the interpersonal. The interpersonal was intimated when Freud discovered transference and countertransference, the beginnings of an awakening of a relationship between patient and the analyst. He also proposed the Oedipus complex, with the child's love for the same-sex parent competing with love for the parent of the opposite sex—a psychodrama of pitting the son against the father in an uncompromising competitive position of jealousy, anger, revenge, and rivalry for mother's affection. According to Freud, if conflict ensues, the child never masters the Oedipus complex, which leads to endless bouts of battles and competition in life, especially with one's mate (a very common occurrence in

couple therapy). As almost every therapist can attest, couples that start out romantically later find themselves in an endless battle, a competition for reciprocity (which I refer to as "tit for tat").

> *Well, I did this for her; now she should do this for me!*

Heinz Kohut

Heinz Kohut (1971), the pioneer or self-psychology is another theorist relevant to the topic of intimacy and whose innovative approach cultivated a new theory of self-psychology mainly for those with narcissistic personalities. He believed the narcissist responds more to mirroring and empathic responses and interpretation in contrast to object relations theorists who believe they respond more to

confrontation. He is one who embraced the importance of mirroring, the need for self-objects, and empathic attunement to help fill the missing function of empathy. Kohut doesn't believe the narcissist distorts rather he is merely misunderstood. His approach includes introspection, validation, and understanding the perceptions of others (not distortions rather perceptions that that come from an operating system empowered by the person's subjective experience. Kohut is often contrasted with Otto Kernberg. Kohut's theoretical stance by its very essence invites closeness and intimacy. Kohut differs from Kernberg in that Kohut believed the subjective experience as truth that the patient does not distort or misperceive reality. To the distraught patient who suddenly is "dumped, a

Kohutian therapist with the empathic mirroring stance might say something like:

> *Kohut: This was not your fault. You are not a trained highly skilled analyst that could diagnose his fragilities when you met. You had no idea that when he would go into fragmentation that he could not sustain a close bond an intimate relationship requires. You had no idea how he would just stomp off and leave you as he did the others. You don't have a crystal ball to predict the future. It is not your fault. Even though you saw the danger signs you fell in love so you must not blame yourself.*
>
> *Kernberg: The warning signs were there but you could not trust your mind because you were so busy idealizing him.*

Melanie Klein

As strange as it may sound, as a classically trained ballet dancer, I appreciate how Klein's concepts have movement that flows back and forth. This has influenced my earlier contributions (Lachkar, 1992, 1998, 2002, 2004, 2008) and clinical practice over the decades. Her concepts are a perfect fit for my concept of "the dance": how one person projects a negative feeling into the other and how the other then identifies or overidentifies with that which is being projected. One of Klein's most valuable concepts was projective identification. Expanding on Freud's defense of projection, she saw this mechanism as a two-way process.

I owe much gratitude to Melanie Klein, for without her I would not have been able to

understand the encounters that occur among couples. Her contributions are invaluable, especially in helping individuals face internal deficits and understand distortions, misperceptions, miscommunications and projections. The interjective/projective process, for example, is a priceless construct in helping us understand the tangled web couples weave (dual projective identification, or what I refer to as “the dance”).

Although influenced by Freud, Klein broke new ground with her pioneer work on object relations, moving away from the father to the importance of the mother. Her concept of splitting good and bad objects is known throughout the literature as the good and bad breast. For Klein the primary experience with

the breast shapes how the child will perceive the world. If a child has good mothering experiences, the child will grow up thinking the world is a good place. By contrast, if the child grows up with the bad breast, the child will grow up thinking the world is dark, gloomy, and persecutory.

In addition to this formation, she introduced us to two positions: (1) The Paranoid-Schizoid position and (2) The Depressive Position. The first position is the earliest state of mind where primitive defenses like shame/blame dominate. The latter is a whole and integrated position whereby one takes responsibility for one's own wrong doings, moving to stages of reparation, mourning, and sadness, along with the desire to repair and make reparation for the damage that

has been done. Inspired by this, I have abstracted these positions and applied them to three stages couples move through (Lachkar 2001,1992, 2010a, 2010b, 2014).

Schizoid Position

Everything is her fault. I blame her for everything that goes wrong. She gets me so upset I don't know what to do. Should I stay married or should I divorce her?

The Depressive Position

Patient: I feel so sad all the time. I go around crying, depressed.

Therapist: This is the healthy part of you. You are not depressed; you are dealing with normal states of sadness and taking more responsibility for your actions. This is a good time where growth and

progress occur and where reparation can be made.

W. R. Fairbairn

Why Do People Stay in Painful Conflictual Relationships? There can always be an external betrayer/ depriver/ rejecter but there can also be an internal one.

Fairbairn helps us understand why people with high conflict personality disorders attempts to destroy all that is good, mainly through envy and sabotage. Never having much of a playful childhood, the obsessive-compulsive remains attached to rigid inflexible internal objects and is unaware of how he envies the object that had warm and playful environment and how he sabotages good experiences. The obsessive avoids pain as he splits his emotional needy self

and projects it onto his partner. Having a low threshold for emotionality, the OCPD may not be consciously aware of what he is doing. Often, intrusive thoughts, feeling, attachments to objects, the desire for "space" become the replacement for unwanted feelings and affects.

> *We were all in Hawaii celebrating my parents 30 wedding anniversary. All he did was complain and make everyone miserable!*

Bonding with the Mother of Pain

> *I hurt myself, I punish myself but at least I know I exist. Better to bond with pain than to have to face the void, the black hole, the emptiness.*

Pain stirs up an amalgam of unresolved infantile issues

Pain becomes highly eroticized/sexualized

Pain is familiar (familiar internal bad object)

Pain is confusing. The lover who can be cruel and sadistic can also be loving and kind.

Pain is linked to internal part of self-one wants to destroy/get rid of

Fairbairn: Attachments to Internal/External Objects

Bad Internal Objects	Bad External Objects
The Wronged Self	The Rejecting Object
The Insatiable Self	The Abandoning Object
The Abandoning Self	The Betraying Object
The Suffocating Self	The Depriving Object
The Betraying Self	The Unavailable Object
The Rejecting Self	The Withholding Object
The Withholding Self	The Painful Object (Mother of Pain)
The Lost Self	The Idealized Object
The Betraying Self	The Sadistic Object
	The Suffocating Object

Attachments to "bad" objects help answer such puzzling questions as:

- Why am I always being rejected? (rejecting object)
- Why am I always being abandoned? (abandoning object)

- Why am I always getting involved with unavailable men? (unavailable object)
- Why am I always getting betrayed? (betraying object)
- Why is whatever I get never enough? (insatiable object)
- Why does everyone else get more than I do? (depriving object)

Attachments to Bad Internal Objects

There can be someone who abuses you, but there can also be a part of yourself that also mistreats and abuses you.

It is not an easy task to wean the patient away from their bad external bad objects and get them to face their internal ones.

> *Why do I stay with a woman who belittles, attacks me, abuses me? Why can't I get rid of her? She is like an albatross around my neck.*

I don't feel the same excitement as before. I need a woman who excites me!

Why am I always attracted to men who are unavailable?

It is better to bond with pain than to have to face the void, the emptiness.

D. W. Winnicott

We must pay homage to Donald Winnicott (1965), another prominent figure whose unique ideas and language have enhanced and expanded the diverse field of object relations. His focus, like Klein's, was on the importance of the early "mommy and me" relationship. He introduced us to varying kinds of mothering experiences—e.g., the environmental mother, the containing mother, the being mother, the "doing mother vs. The "being", the holding mother, and the

background mother—that affect the infant's capacity to be alone (see chart below).

Of all these mothering experiences, which one shall I be? The being mother? The listening mother? The containing mother!? The empathic mother? The thinking mother? The answer is all of them, for they all can work together in harmony and peace, but not the "perfect" mother!

Different Mothering and Bonding Experiences

The "good breast" and "bad breast" mother

The "good enough" mother

The "being and doing" mother

The "holding," "environmental"

The "background," mother

The "containing" mother

The "rejecting," "absent," mother

The mother of “pain.”

The “internal” mother

The “mirroring” mother

The “self-object” mother

The “idealized” mother

The “castrated” mother

The “introjected” mother

The self-hatred” mother

The “internalized” mother

The average expectable or “good enough mother

The True and False Self

Another one of Winnicott’s contributions is the concept of the false self, a self in constant battle with the true self, a self that lurks in the shadows and belies the true self. Winnicott refers to people with personality disorders as those who exhibit a false self, a pseudo self, a persona that

hides the true self. How many narcissists do we know who hide under the guise of the "false self" to prove their superiority and specialness? What about the OCPD who takes on a persona of being the robot, impervious to feelings or what others think of him..

Winnicott's concept of the "false self/true self," also makes an important contribution to both individual and conjoint treatment. In couple therapy, his concept of the transitional space provides a new opportunity for partners to move from states of dependency and interdependency by making use of transitional objects. Winnicott helps us understand how important the mother's role is during the early years of a budding narcissist. Without good- enough mothering, the person cannot function as an adequate partner in intimate relationships. For example, a passive–

aggressive person will constantly try to re-create the parent/child dyad by engaging in behaviors that essentially state, "I am the baby and you are the mommy/wife who is to take care of me!" The narcissist will constantly try to re-create the role of being mother's special child.

Otto Kernberg

Defining the Ego: Why Smart People Do Stupid Things!

Another important contribution comes from Kernberg: What happens to the ego (V-spot) when primitive defenses are operative. For Kernberg (1975, 1992), the ego is an amazing apparatus, a powerful structure responsible for thinking, judgment, and reality testing. Although many authors offer accounts of "ego weakness" or "ego fragmentation," no one says it better

than Kernberg. The ego is the superior agent responsible for memory, thinking, judgment, attention, perception, and the capacity for reality testing. Kernberg loves the ego and reality. It is the agent that provides entree to the unconscious. The function of the ego is to see the world by eliminating memory traces left by unresolved early childhood conflicts or traumatic experiences. It is the capacity to discern the real from the not real. It's like a computer with its own data bank and an anti-spyware program to warn of impending danger (like a virus). As painful as it is to face, the most non-faceable is the very essence of an inner aliveness.

Even though my conflicts are difficult, when I face them head on I suddenly feel a sense of aliveness!

For many the ego is often not "user friendly" because of the inability to heed to its voice and not get swayed by the id or superego. Left to its own devices, the ego absorbs information, integrates it, and seeks out the real from the unreal through the process of reality testing.

The dysfunctionality of the ego helps us understand why people say and do stupid things and the distortions, delusions, and misperceptions of patients. What propels an anorexic to think that he/she needs to lose weight? Why can't a shopaholic stop buying things that max out a credit card? What is it that makes a makes a person with no talent feel that they are special and deserve adulation? What makes an obsessive-compulsive think that scrubbing and re-scrubbing will bring harmony

into their relationships? According to Kernberg (1992), obsessive-compulsives try to dominate and control their environment to guard against real or imagine external threats. They counteract these threats with countless efforts to control their surroundings by counting, measuring, getting things in order, taking excessive steps to avoid illness or getting too close to someone. OCPDs often feel the need to be excessively conscious to keep things from getting out of order to avoid the fear of failure, intimacy, and getting too close to someone (Kernberg, 1992). Along the same theoretical lines, Vaknin (2007) noted that people with obsessive-compulsive disorders are workaholics that use their jobs as a means of gaining control over their external objects.

Wilfred Bion

For Bion, it is an absolute therapeutic violation for people to repeat the same things again and again without learning from experience. Kernberg (1975) and Bion (1967) see such defenses as splitting, projection and projective identification as a direct attack on the ego (thinking, reality testing, perception, judgment, etc.).

Wilfred Bion (1962) takes us a step further in emphasizing how defenses dramatically obstruct one's capacity to think and the ability to see reality. He did however, unlike Klein, see projective identification as a form of undigested words not yet available for communication. In other words, Bion's conception of projective identification has a more positive connotation. It

is a form of communication, an unmentalized experience of an unborn or undigested thought not yet available for communication.

> *When you don't show up for your son's events, you're letting him know what it felt like when your dad never showed up for yours.*

A narcissist woman felt very offended when her OCPD boyfriend kept telling her that something in the house "smelled," that something was rotten. A Bionian analyst might consider this as a projection.

> Th: "You took it personally as if it was an attack against you. What he really was talking about was a part of himself that was smelly, an internal world of feelings of vulnerability and weakness that made him feel bad and rotten inside."

When it comes to listening, one has to be aware of the type of complaint, for there are variety of variations on a theme. There is a difference between a patient showing concern for something that is genuinely disturbing as compared to a patient who complains for the sake of complaining. Abstracting Wilfred Bion's concept of alpha function verses beta elements describes this phenomena referencing his concepts of alpha and beta elements (1967). One might transpose an alpha function complaint as one that has been given thought, a genuine desire to find a solution. On the other hand, a beta element complaint, is a complaint without a thinker, one who bonds with pain as part of maintaining a negative attachment or negative transference with the therapist. To paraphrase

Bion, instead of a "thought without a thinker," to "a complainer without a complaint."

John Bowlby/Attachment Theory

(Withdrawal versus Isolation)

Bowlby developed his theory of attachment from observations of severe disruptions in bonding among children. He used the term *attachment* to denote different types of attachments and the emotional ties to the mother. A secure attachment creates a foundation for intimacy and autonomy. He stresses the difference between withdrawal and detachment. He claims that withdrawal is healthier than detachment because when one withdraws the children left alone for endless hours or babies crying in their cribs without anyone responding to them eventually become despondent and

detach. The child's active protestation of screams, wails, and cries gradually ceases and the child no longer "cares."

To a distraught woman who cannot understand how all the love, good feelings and closeness just went away. "Doesn't he even think about me? Doesn't he miss me? I can't believe all the intimacy and experiences we had together just vanished in his mind."— Bowlby might respond something like:

> *It was obvious that your partner left the relationship abruptly and did not show any signs of missing you. He was OCPD, so even if he does miss you he can't show*

Salman Akhtar

Salman Akhtar's work *Psychoanalytic Listening* provides many different ways to listen

(objective, subjective intersubjective, etc.). When it comes to patient's conflicts and complaints who better than Salman Akhtar the renowned Indian analyst who has transformed the well-known "talking cure" to a "listening cure." Although he does not specifically reference a patient's conflict, his listening techniques have profound application to this subject. He describes four different kinds of listening approaches. (1) Objective listening; (2) Subjective listening; (3) Empathic listening, and (4) Introspective listening as outlined in his recent published book, *Psychoanalytic Listening* (2013), to these he also adds silence and non-verbal as he demonstrates with great proficiency the multifaceted aspects of what seemingly could be a simple therapeutic skill.

How Different Theorists Listen

Just like the "dance" between partners, there is also a dance between the theorists and their psychodynamics.

What follows are various theoretical approaches different therapist responds to the same situation taking into account their diverse theoretical perspectives. For example, the Freudian approach might be acceptance regarding the patient's subjective experience and vulnerability. Klein might address the destructive nature of envy, the distortion and the splitting mechanisms and when needs are persecutory and demanding. Kohut might try to help the patient be more of a self-object. Perhaps Kernberg would address the dysfunctionality or impairment of the ego. Bion might address how

persecutory anxiety gets in the way of the thinking process.

Here's how various clinicians might respond to the following situation:

Wife: I know my husband loves me. But what drives me crazy is that he likes to wear my underwear.

Freudian Therapist: You are responding out of hysteria, a defense against your own prohibited fantasies and instincts.

Kleinian Therapist: No, this is not who your husband is. This is a defense against his mother abandoning him. Since he could not possess her, he became her by wearing her underwear!

Kohut: I totally empathize and understand how you must feel when you see your husband wearing your underwear—that he is not giving

you mirroring and is taking the attention away from you.

Kernberg: I believe Dr. Freud and Mrs. Klein are right. Because of your own sexual inhibitions and repressed thoughts, you are projecting onto your husband your own guilt. Not a good time to consider getting a divorce. While these primitive defenses are operative, you should not make major decisions (ego dysfunctionality).

Fairbairn: Yes, there can always be an external husband who acts inappropriately, but there can also be an internal part of yourself that identifies with the inappropriateness —the part of you that yells, screams, gets hysterical, and momentarily loses her mind. By not getting in contact with your own impulsive acts, you are over-identifying with his behavior.

Winnicott: Your husband must feel very secure and safe with you because he is allowing himself to be his "true self," not a self that is shamed or must hide (safe holding environment). He knows he loves you and you love him. How about becoming more of the "being mommy" for him?

Bowlby: Perhaps this is a way of your husband detaching himself from you, even from his own

body. Because of having a mother who neglected him as a baby, now he is disconnecting from you. You must not take this personally.

Akhtar: Because he competes with you and envies you he then has to become you and then make a caricature out of you.

Summary

This chapter provides various approaches to listening followed by a theoretical and practical advice what to do after one has listened. Learn to listen "like an analyst" (Akhtar, 2013). Then you will hear when a conflict or a complaint is a conflict and when it is a legitimate need? Listening analytically is an essential skill that may take the analyst years to learn. One of the most common complaints patients entering treatment is, “He/she never listens to me.”

Although many of the theorists reviewed do not specialize in couples therapy, nor is their focus on OCD’s, their contributions are invaluable when it comes to integrating various theoretical approaches. Even the most seasoned therapist can become confused when adapting

various listening approaches in concert with perspectives outlined in this chapter.

Chapter Five

The Dance, the Bond, the Drama

About Love

So, what is this thing called love? Who knows about love? Keats? Shelley? Freud? Shakespeare? According to Freud (1914), *love is basically a psychotic state,* a powerful, irrational and all-consuming experience. It is sometimes short-lived, but it can also develop into a more mature love. Freud also talks about being in love with oneself as a kind of narcissistic love (some people never get over this). What Freud forgot to mention is what happens to the person's ego when in this psychotic/blind state. The first thing that goes is the ego. Judgment, reality testing,

rationality, perception disappear during the onset of a love relationship, when being in love is at its most intense.

When people fall in love, they feel it is magical. The mysterious power of love makes everything seem possible. Partners appear to be madly in love at the onset, but suddenly the feelings vanish without an explanation or concrete reason. Many of these couples come into session depressed, with one or the other feeling traumatized and abused by their partner, who initially promised them the world and treated them as the love of their life. But lurking in the shadows are undiscovered primitive defenses that attack and destroy the love bond. The mysteriousness of this syndrome was enough to motivate me to examine the

vicissitudes of love relations, taking into account aspects of aggression, cruelty, sadism, envy, and other primitive defenses that threaten to destroy love and intimacy.

Today people are obsessed with talking about their relationships. In fact, they are so busy talking about them that they hardly have the time to enjoy them. The capacity to fall in love is a basic human need, and we all want to experience this intensely wonderful feeling. However, relationships are not simple; they are comprised of many complex and interrelated aspects of idealization, entitlement, love, shame, guilt, envy, jealousy, hatred, aggression, rivalry, control, domination, and many unresolved oedipal issues, as well as many early unresolved infantile conflicts. When we talk about marital

conflict, we are talking about a kind of love that goes in the wrong direction, primitive idealization that invades and infects the capacity to maintain a healthy loving relationship.

Making love to my OCPD husband is like making love to a robot

I first became aware of why couples stay in painful relationships when writing my first edition of *The Narcissistic/Borderline Couple* (Lachkar, 1992). It was baffling why people who love one another inflict pain on their partners or why they stay in painful relationships and refuse to heed "good advice." The works of Melanie Klein are the most instrumental in understanding how one partner projects a negative feeling onto the other and how the other relentlessly identifies and over-identifies with and internalizes that which is projected. Klein

referred to this process as the introspective projective process, later known as projective identification.

Why is it that these couples never learn from experience and instead engage in interactions that go on and on without reaching conflict resolution? For the narcissist, the movements revolve around the need for specialness, adoration, and entitlement. For the borderline, the movements revolve around abandonment, betrayal, revenge, and retaliation. Although the OCPD may share some of these traits, they are more detached and less involved. The "dance' for the OCPD is more about deprivation, how they project their detached self, making others feel invisible and deprived. Thus, it becomes a dance between needs and deprivation. 'I don't

need anything, so why should you?" Each partner stirs up some unresolved developmental issue in on other. "No, you're not crazy for staying with a man who withholds and deprives you. This can be healthy if we can look at this as a trigger that stirs up part of you that deprives and withholds."

In the dance, the more the OCPD withholds, the more hysterical his favorite partner, the hysteric, becomes. As she becomes more hysterical, he becomes convinced that needs are tantamount to filth and dirt. As he feels increasingly disgusted, he cleans. As he cleans, she screams and clings; and as he withholds, she screams even more. The more emotional she becomes, the more obsessed he becomes with order and regimented routine. Her emotionality

messes up his orderly, compartmentalized world, while his orderliness gives a false sense of security and structure to her chaotic existence.

It is a dance of shame and guilt. He makes her feel shame for wanting time and attention and for wanting to have her emotional needs met, and she feels guilty for always messing up his orderly world. For the obsessive-compulsive, messy needs and emotions call out for constant attention and order. At the deep unconscious level, both the obsessive-compulsive narcissist and his hysteric partner each need what the other has. She needs order and structure, and he needs emotions.

Kernberg's Different Kinds of Love Relations

In Kernberg's *Aggression in Personality Disorders and Perversions* (1992), he describes four kinds of love relationships: (1) normal, (2), pathological, (3) perverse, and (4) mature love. His premise is that in normal love the relationship overcomes the conflict. Internal strivings do not interfere with the capacity to maintain an intimate, loving connection. In pathological love, internal conflict overpowers the relationship (part object) and interferes with the capacity to maintain a loving relationship. It is love that goes in the wrong direction, implying that people who have been traumatized are like emotional cripples in relationships because they link idealization with eroticism. In perverse love, it is the search for excitement.

What kills a perverse love is love. Mature (whole object) love then is an integration of the good and the bad, with more focus on children, community, goals.

Kernberg's Four Types of Love Relationships

Normal: Relationship more important; love takes precedence over conflict.

Pathological: Conflict takes over the relationship; part object functioning.

Perverse: Search for excitement; partners reverse good and bad.

Mature: Goal/task oriented; whole object functioning.

Normal Love

"Normal" couples can argue, banter, and fight, but in "normal/healthy object bonds nothing gets in the way or interferes with the capacity to maintain a love relationship. The

couple pays attention to the needs of the other person, and when things get out of hand are often ruled by feelings that have more relevance and importance. Complaints, arguments, outsiders do not interfere with the love and the desire to maintain an intimate, loving connection.

> *I know my wife gets upset when my mother comes over and starts to tell her what to do and how to run our house, but we just let her say her piece and then go on with our lives.*
>
> *I know my wife gets upset when I watch porno sites, but she knows I love her and am more turned on by her than some artificial sex object.*

Pathological Love

In pathological love bonds, primitive defenses—mainly envy, jealousy, control,

domination, victimization—do get in the way of maintaining an intimate relationship.

When I first met him, I know he thought I was the sexiest most beautiful woman he had ever met. Now every time I see him look at another woman, I go ballistic and become insanely jealous! (envy/jealousy dominate).

He'd rather look at pornography than have sex with me. When he withdraws and detaches, I get clingier and clingier. As he withdraws and turns inward, the more he turns to porno and perverse acts, and I become more attacking.

He is very possessive of me. I knew all the time that resentment was building up as he felt I paid more attention to my kids than to him. I love him and he loves me, but somehow the love got destroyed by his jealousy. He started to become more and more revengeful and

doing cruel and sadistic things to hurt me. Where did the romance go?

Perverse Love

A perverse relationship is dominated by excitement, and there can never be enough excitement. If there were to be any complaints, it would be the desire for things to be more exciting. In the end, one is left with an inordinate amount of shame unless they find partners who collude in their need for constant external stimulation. What kills the perverse relationship, ironically, is love.

As she attacks, he finds more justification for his perverse activities. In the end, he feels persecuted by the bizarre sexual fantasies and his need to find more external stimulation. With

the excitement comes an inordinate amount of shame.

> *He complains he is getting bored, and I cannot continue to feel comfortable with his three-way sexual encounters. He is insatiable, always wanting more and more!*

Mature Love

Mature love involves routine boredom at times. But there is solace, a sense of peace and harmony, and joy in both partners knowing they share common goals in raising a family, are good parents, good providers, and good citizens in the community.

Other Types of Love Relationships

Obsessive/Addictive Love

Romantic Love

Erotic/Exciting Love

Idealized Love

Unavailable Love

Rejecting Love

Lost Love

Abusive Love

Love in the Time of Covid

Many couples complain about the effects that the Covid-19 virus has had on their families, children, social life, and intimate relationships, including having children around for days on end.

> *I remember getting dressed and going to the airport for a conference. My husband would drop me off the airport. Kissing me goodbye, he would whisper in my ear, "Can't wait to pick you up and make mad, passionate love." When I return, he picks me up with flowers and takes me to a lovely French*

restaurant. We arrive home. I hardly have time to unpack, and he's ripping off my clothes. Suddenly we are ordered to wear masks, no indoor dining, no visitors, no friends over to the house. My husband no longer goes to the office; he's home all day in Zoom meetings or conference calls. The highlight of the day is going to Trader Joe's wearing masks and standing in long lines. My suits suddenly are abandoned for sweat pants, and my husband doesn't shave or groom himself until late morning or afternoon. We watch TV, read books, and do work from home. What happened to our romance? We are together morning, noon, and night. Yes, we do love each other, but I must confess that this forced togetherness has taken its toll on our sex life.

The Affair

Another, often life-shattering, complaint that gets revealed in conjoint therapy is cheating and infidelity. In the back of every therapist's mind is the fear that lurking in the shadows is the discovery of "the affair." There is not only the revelation of the affair, putting both therapist and the victim of the affair in a most uncompromising position; there is also the problem of what to do after the revelation. Mrs. F. comes into treatment calling for an emergency session. "When I saw his telephone number on my iPhone, I just knew he was confessing to a long-term affair. My heart began to pound as I listened to the confession!"

After the revelation, there is the problem of how to deal with the initial shock, how to

explore the reasons for the affair, and how to deal with the threats of divorce or initiate the reparative process. "All these years I had no clue he was screwing another woman." At the beginning of conjoint therapy, let the couple know that everything that happens outside of session can be shared during the conjoint therapy except for what the discretion of the therapist deems should be kept confidential. Some therapists terminate the treatment with the idea that the knowledge of the affair contaminates the treatment. My goal as a psychoanalytically trained therapist is to go beyond the affair as a venue for emotional and psychological exploration.

> *After finding out he had an affair, I could not get this out of my mind. I became obsessed every minute. What*

did she look like? What was she wearing? Was she prettier than me?

Common Reasons for an Affair

The person falls madly in love with someone else.

The person feels something is missing in the partners' relationship.

The person acts out of revenge or as an expression of anger.

The person needs many different people for adulation and attention.

The person is perverted and looks for excitement in lieu of love.

The person has lost contact with his/her inner passion and turns to excitement as a superficial substitute.

Stages of the Affair

Disclosure of the affair; process of discovery

Patient reveals the affair to therapist out of session

Partner finds out from an outside party

The actual shock of discovery: disbelief. Did this really happen?

The aftermath of the affair: one partner wanting to know all the details. To tell or not to tell.

To tell or not to tell, that is the question

The Case of Mrs. G

This case is an example of introducing Mrs. G to the special language of empathology. This was designed to help her communicate more effectively with her obsessive-compulsive husband. In the scenario that follows, she was faced with Mr. G's uncontrollable rage and aggression when she attempted to confront him. In order to control and dominate, sometimes the obsessive-compulsive narcissist will resort to force and aggression, as the following case demonstrates.

Mrs. G: There he stood before me, his eyes popping out of his head. His face was turning beet red. I could see the rage coming on. I got scared. I stayed absolutely still. He takes off his jacket and tells me he is not going to my mother's house for dinner—that I can go alone. His rage was triggered by the fact that I moved his stuff while cleaning up for a dinner party. He tells me I had no right to remove his books, music and rock collection from the entry hall table and that I should know how important these objects are to him. He then pushes me against the wall. I bang my head. He starts to leave. I apologize (to placate him) and quietly tell him that we can discuss this later but that we do have plans and it would be nice if we could go my mother's house together. He unwillingly decides to go. He grumbles, pushes me aside

and orders me to get in the car. When we return, he does not speak to me. We go to sleep, not a word. In the morning I get dressed and ready to go to work and very quietly go up to him and say, "I understand how upset you were that I removed your important books, your rocks and other objects. I know what they mean to you, and I will be more sensitive to that the next time. But I'm telling you in advance (in an ever-quieter but firm voice), if you ever push me again or threaten me again, I will call the police to report domestic violence and I'll leave it to them to deal with your outrageous and childlike outbursts. They are bigger, stronger and certainly more equipped than I to deal with your aggression." Even though he tried to block me, I ran out of the house quickly so he would not have an

opportunity to respond, and I stayed overnight in a hotel.

Therapist: Bravo! You did an amazing job. A very impressive piece of work. You were scared, but you did it. [I was impressed with Mrs. G's timing, how she waited to confront her husband until his V-spot went into total emotional recovery.

Mrs. G: This special language, as you call it, is exhausting.

Th: But again, it is not nearly as exhausting as avoiding and denying the escalation of his aggression and violence toward you. He projects into you the helpless and vulnerable part of himself. Then it is you who is the helpless one as he divests the dependent part of himself that he cannot tolerate. Sure, it is much easier for him to have a relationship with his objects (his books, music,

and rocks), because they are constant and always there. No wonder he becomes enraged when someone removes them or makes a mess out of his "orderly" world.

Mrs. G: Why does he have to have them in my face? Why not keep them in his home studio?

Th: That is a good question. I guess he is giving an unconscious message about his attachments.

Mrs. G: You mean letting me know that his possessions are more important than his wife?

Th: Not more important. Safer. Those things he can control and keep in order.

Mrs. G: That makes me feel better. At least I know it is his problem. But what do I do?

Th: Exactly what you did. You contained him and mirrored him. Yet you held

onto your boundaries and did not let go of your hurt feelings. You waited until he calmed down, and at the opportune time you told him what you expected. Most important, you did not identify with his negative projections and give way to his aggression.

Mrs. G: Different than what I used to do, huh?

Th: Right. Remember last week when he stormed out of the house? He thought you would be waiting around for him. Instead, you went out with your friends, and he was the one who started to panic.

Mrs. G: But isn't this like game playing? Why can't I just talk to him like a normal person?

Th: It feels like a game, but it's not.

Mrs. G: I know I was scared. I used to cry and cry and then apologize to him profusely, fall on my knees, beg him to forgive me, and tell him again and again, "I love you. I love you." I was stupid.

Th: Not stupid. This has more to do with anxiety and your abandonment issues. We need to stop now.

Mrs. G: I don't want to leave.

Th: Then I won't say goodbye. Instead, I will say until next week when we meet again and continue where we left off. This is our special language.

Discussion

This case has all the elements of the OCPD —containment, impulse control, empathy, and more. The dramatic point occurred when Mrs. G patiently waited, like a fox, and just at the right

moment confronted Mr. G with the fact that if he ever laid a hand on her again or blocked the door, she would seek outside help. For someone with an impulsive, histrionic personality, Mrs. G did remarkably well. She remained absolutely silent and refused to get into a battle with her husband. The next day he called and offered his most humble apology. Said Mrs. G, I told him that I accepted his apology but that what I said holds true. "One more outburst, blocking of the door, or laying a hand on me, the Domestic Department of the LAPD will show up at our door. I love, respect and admire you very much," I told him. "I'm sure that this will not lead to such a drastic step, but never again."

Therapists often become frustrated in trying to break through the bedrock layer of defenses

operative within the obsessive-compulsive. The therapist's most important work in the case of Mrs. G was to help the patient not only disidentify with her husband's abuse but also to give her the necessary communication skills to deal with the situation. An obsessive-compulsive like Mr. G has a tendency to distort and feel attacked by the emotions of others. Thus, it becomes imperative to be impeccably attuned to Mr. G's potential reaction so that what becomes transmitted is not an attack—which can disturb the obsessive-compulsive's perfect universe.

Cross-Cultural Complications

Therapists cannot ignore the cultural, ethical, and religious aspects of therapy. In treating couples from various cultures, we deal with societies that identify with destructive leaders,

endless pain, sacrifice, and victimization. These are societies that do not stress separation from the maternal object but instead maintain a lasting bond in a maternal fusion. The dilemma faced by many therapists when treating cross-cultural couples is that they may not be sufficiently knowledgeable. However, the therapist need only be familiar with some basic customs and traditions to effectively analyze the role culture plays in strained relations between cross-cultural partners so that the healing process can begin.

Self-psychology appears to be the most effective treatment modality in cross-cultural therapy. It offers mirroring and empathic responses designed to scale nearly impermeable walls of defense and object relations to contain and deal with the aggressive and destructive

aspects of the relationship. The grandiose self of the narcissist pompously purports that his or her ways are best. How do we discover a self within the cultural narcissist who comes from a shame society and does not exist outside the context of the group? It is important for the therapist to probe deeply enough to find pathology within the individual, and discover the vertex where conflict exists within his or her own culture. Chapter 6 will explore therapy with cross-cultural couples in more detail.

Chapter 6

Cross-Culture: Where East Meets West

It has taken me years of analytic training to understand why couples who love one another can be cruel and sadistic. To this day I still find it challenging to witness how primitive defenses invade and contaminate the love bond (envy, jealousy, shame, guilt, control domination).

Globalization brings in a new world of terrorism, violence, domestic abuse, and the need for therapists to take into consideration these aspects when dealing with spouses from other cultures. I began to see a link between terrorism and domestic violence, particularly

involving the malignant OCPD. Understanding this kind of cruelty and aggression at the global level has been enormously helpful in understanding aggression and cruelty at the domestic level—especially in the treatment of cross-cultural couples. In mediation, the malignant OCPD may be seen as a "court terrorist" (see Chapter 8). Many women—especially borderline, dependent, and histrionic women—tend to hook up with men from other cultures whom they tend to idealize and are mesmerized by them.

> *I just love Middle Eastern men; they seem so masculine. They are real men!*

Cross-Cultural Couples

Today, our offices are beginning to look like a mini-United Nations, with people from many

ethnic groups. “Marry me, marry me!” can actually mean “Marry me, my family, my religion, my ideology, and follow the child-rearing practices and the political heritage of my culture” (Lachkar 1992, 1993a, 1998a, 1998b, 2004, 2007, 2008a, 2008b, 2012). In today’s clinical practices, we see many couples who bring to this country old sentiments and archaic injuries, which they relentlessly hold onto. The refusal to adapt often presents the therapist with real therapeutic challenges.

This chapter is based on more than two decades of experience (Lachkar, 1992, 1998, 2002, 2004, 2008) and clinical practice, as well as, oddly enough, psychohistory, in which I ventured beyond psychoanalysis and delved into the Middle East, examining the child-rearing

practices and the historical, mythological, psychological, and religious past of the Arabs and Jews (De Mause, 2000b, 2002a, 2006; Lachkar, 1983, 1991, 1993a, 1993b). This influence segued into my work on cross-cultural couples. Although couples think they are battling over sex, money, or custody (external events), the squabbling is more over self-identity, boundaries, dependency needs, rivalry, betrayal, abandonment anxiety, and entitlement. Similarly, contentions in the Middle East are not really over land or occupied territories, but more about shame, control/domination, victimization, saving face, honor, betrayal, self-identity, and oedipal rivals. Some of these themes are universal, for we all have a need to master our oedipal rivals (relational or political) to preserve our identity or the collective group's identity.

The preservation of the group self becomes more important than life itself.

The International Arena

Moving from the domestic to the global, I start with an example of group mentality the group mind. Kristallnacht, which took place in 1939—was examined in an article written by Professor Peter Loewenberg (1987). Loewenberg recounts how Hitler's motives in Germany were to confiscate money and wealth from the Jews. It was astonishing and curious when German people with strict morals, Christian values, respect for their neighbors and other people's property, and known for an obsession with orderliness/cleanliness could morph into mass hysteria. They burned every synagogue and later took every opportunity to

degrade and humiliate the Jews (e.g., spitting on them, not providing them with toilets). Suddenly the Germans' behavior because the opposite of order/cleanliness, morality, and respect. To them Jews became the filthy pigs! Schweinhunds! Germans tried to prove their superiority by projecting their own depreciated and unwanted dirty or anal parts of themselves onto the Jews, and then relished the anguish and humiliation they were imposing by debasing the Jews, treating them as contaminants. They postulated a new degradation, and in fantasy placed themselves in the position of the Jews to experience how it felt. According to Loewenberg, transforming Jews became a triumphant fecal orgy. In my analysis, this was a reflection of harsh child-rearing practice by obsessive-compulsive mothers who forced their

children to be perfect, resulting in an ultimate sadistic superego—that is, superegos run amok (Loewenberg, 1987).

A second example of the group mind took place at the funeral of deceased Korean President Kim Jong-un where his starving, impoverished people stood in cold freezing weather in a trance-like state, shedding tears—or what I refer to as "Crocodile Tears"—for a leader they idealized and revered.

Treatment of the OCPD in Individual and Couple Therapy

Waving his nationalist flag, the OCPD brings with him to this country his grandiose, perfectionistic, and ritualistic traditions, to which he rigidly adheres. This provokes him to criticize everything that is different from the

customs of his country and to relentlessly cling to his rituals and traditions. He refuses to adapt and will do anything to force his ways and beliefs on others.

While the OCPD is concerned with loyalty to their country, the narcissist is more concerned proving their specialness. “The Americans don’t know how to cook! They should learn from the French!” In more severe cases an OCD patriot will spend his life trying to revenge a leader who is felt to have betrayed his country.

This differs from the OCPD narcissist who could care less about ritual and traditions; rather, the narcissist has an overriding nationalistic belief that his country/religion is superior.

Patient: Men here in America are big fools; they treat their women as equals. In

my country women must obey the men.

Therapist: Yes! I understand in your country it is okay to force your wife to be obedient. It must be quite a shock to find that in our country we treat women as equals. This is new to you. I'm sure in time you will find a way to adjust. You must love this country; otherwise you never would have left yours!

Cross-Cultural Psychodynamics: Psychohistory, Mob Mentality, Group Psychology

So, what is the glue that holds groups together? These are people pre-programmed and pre-scripted to identify with certain group myths/fantasies or leaders whom they revere and idealize. In psychological terms, this behavior is known as a collective group fantasy, in which

people band together as one in harmony and total synchronicity! “We are now one!” Not a far cry from cult-like behavior.

Renowned psychoanalyst Wilfred Bion’s work on group psychology provides a methodology for understanding cult-like behaviors in groups and is pertinent to psychohistory. He shows how people are pressured and coerced to act like sheep and collude with certain leaders. In many of my earlier contributions, I have applied Bion’s formulation of group psychology to the study of cross-culture, not only in my work on treating cross-cultural couples but in analyzing how people in groups bond together and identify with destructive leaders. More than any other psychoanalyst, Bion understands the primitive,

unconscious mechanisms operative in groups and how people identify with charismatic destructive leaders and collective group myths. Many of these group myths are based on archaic injuries that were never mourned or losses that were never dealt with (e.g., the burning of Temple Mount).

In addition to group psychology as a methodology to help us understand cult-like behaviors, it also explains why people in groups tend to fuse, collude, and find a scapegoat—an enemy on which to target their hatred and project their envy and aggression. It explains why people in regressed groups have twisted minds and form idealized bonds/attachments, as well as parasitic bonds, with destructive leaders

who collude with the group's collective myths and fantasies (Bion, 1961; Freud, 1979).

Psychohistory

In today's contemporary clinical practices, many therapists are completely baffled by the inextricable, complex link of culture, customs, and traditions connected to individual and self-identity. Psychohistory and group psychology are the two disciplines that I have found most valuable in my treatment of cross-cultural couples.

Psychohistory offers a broader perspective from which to view cross-cultural differences using new tools and concepts to examine history via a psychohistorical lens. This allows a better understanding of individuals, groups, nations, governments, and political events—very much

as a therapist analyzes the couple as a symbolic representation of a political group or nation. Psychohistory analyzes historical events, just as a therapist analyzes a patient's dreams. Psychohistory takes into account group myths and collective group fantasies (cult-like behavior or the "mob mentality).

To penetrate seemingly impermeable borders, the psychohistorian explores the culture's religion, ideologies, child-rearing practices, the leaders that members identify with, and their collective group fantasies and myths (Loewenberg, 1987, 1996). The psychohistorian also takes into account the culture's ideology, rituals, and mythology as well as the varying psychodynamics—for example, how each culture experiences such

dynamics as shame, honor, saving face, guilt, dependency, envy, jealousy, devotion, and the meaning of self.

The question often arises: What gives us the right to analyze people, groups, and dictators, putting them on the couch without ever meeting, treating, or evaluating them in our clinical offices? No, we do not have the right to analyze the leaders themselves, but we do have the right to analyze the policies that they espouse in order to identify the salient traits of these inflexible group leaders. Not everyone adheres to the myths, beliefs, or ideologies of dictators, but the ones who do are the ones who perpetuate the aggression.

So who is right and who is wrong? When we treat individuals or couples from varying

cultures, we must presume there are universal laws and certain developmental processes that we share as human beings. Our developmental research shows that there is an epistemological instinct to grow and develop and a universal need to overcome our oedipal rivals. In today's contemporary clinical practices, many therapists are completely baffled by the inextricable link of culture, customs, and traditions connected to self-esteem. Holding onto one's culture is closely aligned with one's self-identity and group identity—the collective group self: "If you get pregnant out of wedlock, you not only shame yourself but our entire society."

How do we distinguish a "normal" culture/conflict from a pathological one? The mental health of one's culture is another

culture's pathology. Some say terrorists or jihadists are normal people who merely have been brainwashed to fight for a cause. Others have referred to this as a culture of intimidation in which repressed behaviour is rewarded and individual rights are demonized. But according to Western psychological studies and standards of human development, repressed behavior and the suppression of human rights are not normal. To penetrate these seemingly impermeable borders, we must take into account certain aspects of culture and the identification with and idealization of group leaders that perpetuate the conflict.

The reader may view these comments as stereotypical, but the main focus of analyzing cultures and their leaders is to help therapists

treating people from different cultures get a sense of the variations in cultural beliefs. This allows partners to communicate effectively with each other.

The Mob Mentality

Mob mentality is that of a group banded together like sheep, or a school of fish. The individual no longer exists. As Wilfred Bion states, these are thoughtless thinkers, or thinkers without a thought—those who identify with certain leaders and revere fantasized role models, heroes, and messianic saviors. These leaders give those in the group a sense of purpose and allow them to feel they can make meaning out of the meaningless.

> *Gee, I want to grow up just like my terrorist uncle!*

We never wanted to drive the Jews into the sea, but now we have meaning and purpose in our lives!

Group Psychology

Group psychology, like psychohistory, helps us understand cult-like behaviors—why people in these regressed groups tend to fuse, collude, conspire to find a scapegoat or fantasized enemy on which to project their hatred, envy, and aggression. Group psychology helps us understand how people with twisted minds form idealized parasitic bonds with destructive leaders who collude with the group's collective myths and fantasies. Furthermore, it also shows how people in groups/nations are blindsided by narcissistic leaders who lie, cheat, manipulate, and perform horrific acts against humanity. Idealization of a leader is a defense mechanism

that gets in the way of seeing reality; their followers view them as gods who can do no wrong. Leaders like Hitler, Mussolini, Milosevic, and bin Laden knew how to manipulate the group's omnipresent fear of imminent danger (real or imagined). Serbian President Milosevic tortured his people yet stood above the crowd while it cheered.

I am your father and will save you!

Group psychology is the study of group myths and group fantasies

Cult-like behaviors dominate irrational/delusional thinking, group myths

Followers bond through collective group mutual fantasies

Group idealizes and identifies with the destructive group leader

Members of the group form collusive/parasitic ties with one another.

Examples of group myths:

> *Islam is a religion of peace; the Armenian Holocaust did not exist!*
>
> *We know our leader is destructive, but he is our father and our savior, and we worship and revere him.*

Malignant OCPD Leaders

The malignant narcissist is usually a leader who uses their omnipotent sadistic fantasies to live out a cause and offers a fantasy of power and superiority Someone like Mr. Milosevic, the Serbian war criminal, may fit this description. "We killed the Albanians for a good cause. I am here to protect you." Under the guise of the "good cause," leaders can out act their worst aggressions. Sadism and paranoid features are the most common syndromes in the malignant narcissist, which drive them into fulfilling their

own self-serving, political aspirations and become the rationale for destructive acts of aggression.

> *Osama bin Laden claimed the September 11 attacks were in defense of his own people, the "Will of Allah."*

Why are people blindsided by narcissistic national leaders who run the gamut from ineptness to lying and cheating, torturing, terrorizing to performing the most horrific acts known to humanity? The psychological response would be idealization. People who revere destructive leaders see them as gods who can do no wrong. Idealization is a defense mechanism that gets in the way of seeing reality. These destructive leaders manipulate the group and get group members to join forces in search of an enemy to blame. Individuals in North Korea

who had been horrifically abused/mistreated lined up in droves wailing, shaking, crying, standing in freezing, snowy weather hours on end mourning the death of dictator Kim Jong II. Closer to home, former President Trump, undeniably a narcissist, ignores facts, speaks disparagingly of anyone who disagrees with him, shows no respect for democratic institutions, and is unable to compromise; yet his adoring followers are undeterred.

The Cultural V-Spot: The Original Narcissistic Archaic Injury

Do countries/nations have a cultural V-spot, whereby an entire culture adheres to certain group fantasies based on painful archaic injuries, myths, and sentiments handed down from generation to generation? Do these V-spots blow at the slightest provocation? In noting the

parallels between marital and political conflict (Lachkar 2008a, 2008c), I questioned what it is that traumatically bonds the countries together. Do countries look at each other and say, "Hey, you hurt our feelings!" Transposed to the cultural level, the vulnerable spot might sound like, "Don't insult our Prophet!" and "I'd rather die than give up allegiance to my country!"

These archaic, traumatic injuries have been sustained through generations of violations and abuse, keeping governments forever embroiled in endless feuds. The noted psychiatrist Carl Jung (1973) referred to this as the collective group unconsciousness. Inspired by Jung, I see it as a parallel to the cultural V-spot, a collectively shared archaic injury from the mythological or

historical past that evokes painful thoughts and memories for the group.

A Korean female patient would blow at the slightest provocation and hold on to her rage for months. Culturally speaking, Korean women (who were victims of war crimes) would get into a state that they refer to as *han*. Historically, these women were abandoned and had to fend for themselves, and hence developed more aggression than their sister neighbors.

Bonding with the Culture

Most theoretical constructs and formulations are designed for Western psychoanalysts and other mental health professionals who are trained early on to help patients "find" their true self, their individual self, their differentiated self, the nascent self. But these concepts are

virtually nonexistent when it comes to some other societies. So what is meant by bonding with another person's culture? Does it mean we have to convert to their belief system? No, but it means we should try to understand something about their religion, customs, child-rearing practices, mythology, traditions, and taboos, and how they use or misuse aggression.

What is considered abuse in the West might be considered perfectly acceptable in another culture. Some cultures may regard being unfaithful to one's spouse, particularly on the part of the male, as an inevitable occurrence. In fact, affairs abound in Western culture. Many beliefs espoused by Westerners are often debunked by other cultures: "The United States is the great Satan." In treating couples from

various ethnic backgrounds, we often witness a great deal of what we might consider sadism. Although the individuals involved are not terrorists, from a Western point of view, they may engage in the mistreatment and violation of woman and children or the violation of human rights.

Another important aspect in bonding with the culture is becoming familiar with the foods, traditions, and holidays of our foreign patients. This gives the foreign patient a sense of being with a kindred spirit. For example, our Middle Eastern patients might appreciate being served mint tea in special glasses. Arabic folk music might add a nice background touch. Many therapists resent this because learning new ways of communication might be too taxing and

require that they learn an entirely new discipline. I contend that the therapist need know only a few words of the patient's language or a fact or two about his or her tradition to initiate a bonding experience. One might learn how to say a few words in other languages, like "hello" *(buenos dias, sal'am, shalom, guten tag, buon giorno, bonjour),* "goodbye," and greetings for specific holidays (e.g., Hanukah, Christmas, Ramadan, Good Friday, Passover, New Year). For example, one Jewish patient wished her therapist a Happy New Year in September, and the therapist responded, "Oh, I thought New Year was in January."

Many of our theories are specifically blueprinted and pre-scripted for our culture. Of all the theories, I believe Heinz Kohut's (1971,

1977) concept of self-psychology, with its mirroring and empathic techniques, is most adaptable and suitable for the treatment of individuals and couples of varying ethnic backgrounds, ideologies, traditions, and values. Kohut's theory offers the most obvious approach for dealing with persons from a different culture, and especially those who have not assimilated or adapted to Western culture. Because of its emphasis on intersubjectivity, self-psychology appreciates that each society has its own unique roles and customs and that patients and the therapist have different subjective viewpoints.

The intersubjective experience does not focus on right and wrong but rather on understanding the issues surrounding the conflict. Concepts from self-psychology provide

the perfect language for empathizing with the patient's vulnerabilities and variations in perspectives. On a more cautionary note, empathy is not to be confused with acceptance of the person's aggression; rather, it should mirror the person's frustration regarding the ability to adapt or the resistance to adapt: "So, because men were allowed to beat their wives in Saudi Arabia, you think I can understand how you might feel it is okay to do the same in this country?"

Techniques for Treating Cross-Cultural Couples

Individuals who are so embedded in tradition and ideology can be a source of great frustration for the therapist. In such instances, therapists must relinquish the grandiose thinking that they will cure the patient or change the patient—for

example, by believing that if he loves his partner, loves our country, loves the therapist, the foreigner will change. Again, going back to Kohut, if the therapist merely listens to the conflict, attempts to understand the conflict, mirrors the conflict, or is empathic to it, the therapist will be providing an important therapeutic function.

Treating emotional vulnerabilities and communicating with individuals from various cultures entails taking into consideration their cultural and qualitative distinctions. In Eastern cultures, it is not enough to understand what honor or peace mean without understanding how these are inextricably linked to saving face. The dynamics involved in treating cross-cultural narcissists take on an entirely different shape.

This includes such contrasting variances as dependency, entitlement, honor, peace, and sense of self. What shame means to a Westerner may not be what it means to a Middle Easterner or an Asian. What dependency means in Japanese cultures is in sharp contrast to what dependency represents for the Westerner. One cannot understand shame without encompassing the concept of "saving face" or sense of self in Asian and Middle Eastern societies. Furthermore, to understand the concept of self, one must take into account the differences between an individual self and a group self.

Cultural Psychodynamics

Western therapists need to be aware how such dynamics as shame, honor, dependency, take on an entirely different shape in other

cultures. The same holds true for guilt, envy, jealousy, dependency, true self and false self (*tatemae* and *honne*, respectively, in Japanese). There are hierarchical positions in many cultures in which deference to elders and parents comes first, with wives last on the list. For Koreans, it is not enough to analyze someone's anger or rage without considering the Korean concept of *han* ("rage") with its deep historical significance. A Western psychoanalyst will encourage the patient to express his/her needs as directly and openly as possible, but a Japanese patient will remain silent, waiting for the analyst to offer what he or she needs (*amae*). Miyamoto (1994) presents a critique of the "closed society" of Japanese bureaucracy. This Tokyo-born psychiatrist refused to accept the formalized Japanese lifestyle and ventured out to rebel. He

used his insight as a psychiatrist to note the glue that holds a xenophobic society together.

I devised the term the "cross-cultural hook" to mark the most dramatic variants between cultures, basically hypocrisy. The therapist outlines an example so outlandish that it presents a glaringly different view and perspective of the conflict: "I believe you are telling us that adapting is very difficult. It would be as though I went to Saudi Arabia, had to give up my car, wear a burka, and be completely subservient to my husband or risk being stoned to death or having a finger cut off." Applying the cross-cultural hook to a Middle Eastern man who complains that his wife disobeys him and only listens when he beats her might entail the following: "Yes, I do understand this is your

tradition. But imagine if your wife attended a meeting in Saudi Arabia where women are not allowed to sit with the men (except one time when Queen Elizabeth visited and was referred to as His Majesty Queen Elizabeth) and decides to sit with all the Saudis in shorts and a T-shirt. How would you respond if your wife did this and said it was customary in her country?"

As a psychohistorian who has treated cross-cultural couples for many years, I have found four techniques to be invaluable:

(1) Use the aforementioned cross-cultural hook to find pathology within the cultures involved.

(2) Move into Kohutian mode to mirror and reflect what you hear.

(3) Bond with the patient by becoming familiar with a few words in the patient's language and a few customs from his/her country. Rather than getting into a battle as to whose culture is more

psychologically correct, recognize that beneath the surface differences we all speak a universal language based on the desire to be heard, respected, and loved.

(4) When stuck or in doubt, mirror. Find the area of vulnerability or the cultural V-spot by mirroring and empathic attunement that show your understanding of the resistance to change and adaptation: "It must be quite a shock to come to this country and find women so free, not only with their bodies but with self-expression. This is very unlike women in your culture, who are raised to be compliant and obedient to their husbands and their fathers."

Mohammad and Christine

Christine spoke about when she and Mohammad first met: "He was so charming and made me feel as though I was the only woman in the world. I was mesmerized by him. He couldn't keep his hands off me and kept telling me how I was the most beautiful woman he had

ever met. He said it excited him to be with an American woman." Christine and Mohammad had been married two years when Mohammad suddenly told Christine he no longer found her attractive and would explore sexual relations with other women. Yet he wanted to remain married. He told Christine this quite openly, thinking that she would understand that one woman was not enough: "In my country, it is customary for men to have up to four wives."

The therapist reminded Mohammad how that may be the custom in Syria, but in America it is customary to love and cherish one woman according to the marital vows he had pledged. Mohammad said, "I did pledge to be faithful and to honor her, but things change. In my country it is called *Inshallah*. This means it is the will of

God/Allah. The Almighty has the power to change our minds at his will." Christine was absolutely horrified, indicating that she had no idea that Mohammad could possibly do these things or even think like that.

After extensive mirroring attempts to tell Mohammad it was understandably difficult to adapt after years of being preprogrammed with the concept that having many wives is acceptable, I interjected the cross-cultural hook: "It would be as if I got pregnant and went to the Taliban to get an abortion. They would cut my uterus out, or they would kill me."

When communicating with a person from another culture, therapists often get very frustrated, not only because they may not understand the client's culture but also because

some clients may present enormous rigidity to change and adaptation. It is therefore suggested that the therapist give up "memory and desire" (Bion, 1967, p. 143) as well as change and be there as a self-reflecting object to mirror the conflict with appreciation and empathic attunement. If the patient is Japanese and her partner is American, the therapist might say, "I see that she wants to go to a movie but doesn't tell you directly and expects you to be a mind reader. In Japan this is called *amae*, whereby one does not ask for what he or she needs but expects the other to understand this need by reading the eyes and body language. I can understand what a foreign concept this is for an American."

Transference and Countertransference Issues

We cannot overlook the therapist's transference and countertransference issues when treating cross-cultural couples. Yi (1995) emphasizes that we cannot ignore these issues, especially with Asian clients. Men who abuse women under the guise of tradition or culture evoke enormous transference and counter-transference reactions. Therapists who have had personal backgrounds of abuse may not be able to separate or understand violence that is culturally and governmentally acceptable from violence that is prohibited. Any aggression against women expressed from people who come from cultures in which mistreatment and denigration of woman are rampant can elicit tremendous rage in both female and male

therapists raised with democratic values in a society that supports female and human rights. Following are some examples of common counter-transferences that occur in working with cross-cultural couples:

Therapist is not culturally sensitive.

Therapist has an inadequate understanding of the patient's culture.

Therapist goes overboard trying to adjust to the patient's culture.

Therapist goes overboard trying to please.

Therapist is frightened of the person's culture and aggression.

Therapist identifies with the projections of shame or guilt.

Therapist may be denying that there are cultural differences.

Therapist may overreact to please the patient.

Cross-Cultural Psychodynamics

Dependency, guilt, shame, honor, control, and domination in one culture takes a different form in another. Even words like "opportunity" and "honor" can be poles apart. In the West we associate the term "opportunity" with one's freedom to flourish, but in the Muslim world "opportunity" could mean the permission to stone, slaughter, or even behead a woman who exposes her arms or face or goes out in public unaccompanied. The same holds true for terms such as "honor" and "peace." In Islamic regimes, only when all the infidels are destroyed can there be peace and harmony. It is not enough to understand shame without understanding the need to "save face." Then there's the group self vs. the individual self (Roland, 1988, 1996).

Most Western psychotherapists will note that when two individuals are interacting they will express how they feel. In Asian societies, the prevailing belief is that there is no need to express how one feels because the assumption is that the other person will just intuitively know this, the form of dependency called *amae*.

Treating emotional vulnerabilities is not enough; one must also understand the cultural and qualitative distinctions. These points are examined from a psychological and psychoanalytic viewpoint, incorporating both the intersubjective and objective experience. Let us now take a few moments to explore these various dynamics and how they may apply from a cross-cultural perspective.

How does a Western therapist address the various psychodynamics that present themselves with different cultural orientations? For example, in Asian and Middle Eastern societies the self does not have the same significance as it does in Western societies, which are more "me" oriented. In the East, honor is achieved via the group. Even the meaning of free speech takes on a different form. In the West we have wide freedom of expression, while in other cultures freedom of expression is not encouraged—and in some cases is condemned and dominated by religious rights. What follows are common conflicting dynamics between our cultures.

Some of the varying dynamics that cause problems for cross-cultural couples include:

Shame vs guilt

Envy vs. jealousy

Domination vs. submission

Attachment vs. detachment

True and false self (honne vs. tatemae)

Individual self vs. group self

Hierarchical and obligatory bonds

Projection and projective identification

Shame vs. Guilt

Shame is basically an Asian and Middle Eastern dynamic, whereas Europe and the United States are guilt societies, or scapegoats. Scapegoating is a common phenomenon to avoid the "enemy" (real or fantasized). Shame is a matter between the person and the group. Shame is concerned with what others think, whereas guilt is a matter between a person and his or her conscience (superego). Shame is the need to hide one's true

inner feelings, which are repressed. In Japan and other Asian and Middle Eastern societies, shame is a major sanction. People are chagrined; they are heavily invested in shame and "saving face," as opposed to guilt. Obedience to others is of utmost importance. One must strive not to compete, to show feelings, to induce competition, or to be unique. In a shame society, the parent will use ridicule or humiliation to keep the child in check. Professor Peter Berton (1995), an international relations and foreign affairs scholar and psychoanalyst whose main area of expertise was in East Asia and Russia, testified that the most common threat that a Japanese mother will use to discourage her children from certain behaviors stems from ridicule: "People will laugh and make fun of you (*Warawareru Wo Yo*)" (p. 10).

Another major difference between guilt and shame is the ability to mourn, to face one's losses, and to come to terms with guilt. In most Christian societies in the West, people are dominated more by guilt than shame. According to Melanie Klein (1957), guilt occurs in the depressive position, when one faces grief and desires to make reparation for all wrongdoings. It is interesting to note how citizens of countries such as Germany allow themselves to mourn, to face their destructive acts, and to make reparation. Germany is a good example of a country that has developmentally evolved to a state of wishing to make atonement. This contrasts with the Japanese, who have never come to terms with their guilt (Lachkar & Berton, 1997) and will do everything possible to save face and cover up. Does Japan hide its war

crimes because of shame? In the West, guilt is relieved by confession and atonement, but chagrin cannot be relieved in this manner. A man who has sinned can get relief by confessing either to a priest or to a secular therapist. This may partially explain the relative lack of popularity of psychoanalysis and other psychotherapies in Japan.

Envy vs. Jealousy

Klein (1957) made a distinction between envy and jealousy. Envy is a one-part object function that is the most primitive and fundamental emotion and seeks to destroy that which is enviable. “As much as Osama loves what America possess, he must seek to destroy her!” Jealousy is a three-part relationship where

one admires and wishes that what others possess could be theirs.

Dependency (Amae)

The Japanese concept of dependency needs (*amae*), the desire to merge with others, is reflected in the intense long-term bonding relationship between the mother and the infant. The eminent Japanese psychoanalyst Takeo Doi (1973; see also Johnson, 1994) called *amae* a key concept for understanding the Japanese personality structure. Doi acknowledges that this longing for dependency and presumption of another's benevolence can be fulfilled in infancy but that it cannot be easily satisfied as one grows up. The concept of *amae* is very complex and has been the subject of much debate among Japanese and American analysts. Some scholars

have intimated that the need for *amae* beyond infancy is a sign of pathology in Japanese society (Iga, 1986). *Amae* is a form of dependency relating to the mother's intense internalization and identification with her child's needs, especially her male child. It embodies the feelings of dependence that all normal infants have toward the mother, the desire to be passively loved and the unwillingness to be separated from the warm mother–child circle and cast into a world of objective reality. It manifests itself as the desire to merge or fuse with others. However, this love creates extreme forms of ambivalence and hostility. Under the guise of closeness, the mother will co-sleep, co-bathe and, in some instances, engage in incest by masturbating baby boys to relieve their erections (Adams & Hill, 1997). The need for *amae*

continues into adulthood and manifests itself in a variety of social conventions and characteristics. The following is an example of how this might manifest within a cross-cultural relationship.

> *Tony asked his Japanese wife if she wanted to go to an Italian restaurant. Tamiko agreed. At the end of the evening, she became outraged because she had wanted to go to a Japanese restaurant. When Tony asked why she didn't say anything, Tamiko replied that she was silent because he "should have just known where she wanted to go. "In Japan we read carefully the lips and eyes. That tells us everything."*

Many modern Japanese women today are marrying Americans because they are frustrated by having to stay home and take care of finances and children while their husbands work long and tedious hours, even when they're not in Japan.

For example, Roberta could not understand why her Japanese husband, Yoshi, came to this country to have a better life and still worked long hours, leaving her to care for his three kids. After work he would go out with the guys for sake and beer and come home late, too exhausted to have sex. In treatment, the therapist must be very careful not to shame or humiliate the Japanese man. Rather the therapist must say things such as, "It is nice for couples to do things together. Working long hours and going out later is typical in Japan, but here husbands are more involved with their children. It would be as if I went to a conference in Japan with all men and sat among them [the cross-cultural hook]. They would be shocked, and then I could say, 'Well, in our country woman and men sit together.'"

Individual Self vs. Group Self

America is an individualistic culture, where emphasis is on self-development. Asian and Middle Eastern societies are collectivistic cultures, with emphasis on the group self. Even more pervasive is the cultural group self or the collective group self. According to Yi (1995), American culture emphasizes the autonomous self, which stresses uniqueness and self-expression, whereas Asian societies lean toward an interdependence that stresses heavy reliance on the group. But when we talk about a cultural self, are we talking about an individual self? A group self? A self-actualized self? A collective group self? Miyamoto (1994) referred to this selfless devotion to the group (e.g., not taking allowable vacations) as Japanese masochism.

Who is the we, and who is the *you?* Most Western psychotherapists assume that there are two individuals interacting together, or as Roland (1996, p. 72) clearly stated, an "I-self" and a "we-self," with more or less firm ego boundaries between these entities. According to Roland, the Japanese therapist assumes a different kind of self-based on a we-self, which is fundamental to the Japanese mode of hierarchical relationships. How can I be a "we" with you? Roland explained that this is quite different than American egalitarianism. Turning again to the *amae* relationship, "When we are a 'we,' I don't have to tell you how I feel. You will just know."

Some may experience the individual self or the Me!-Me!-self as an extreme form of

narcissism—"We are better than you!" From a cultural perspective, it can be perceived as an inherent trait or dynamic within our Western culture. Amae presents difficult challenges for the narcissist (lack of empathic attunement and disdain for having dependency needs). Although the OCD may also have issues around dependency needs and empathic attunement, the main concern is fear of emotional contamination. "Feelings! That's opening a can of worms! Her neediness disgusts me!"

Hierarchical and Obligatory Bonds

Therapists must have some knowledge of obligatory relational bonds. In Middle Eastern countries and Asian societies, parents and elders come first; deference and devotion to parents is a strong, long-enduring attachment. This also

occurs in other societies. The following is an example of an OCD wife who went to Israel for the first time to visit her husband's parents. It was her birthday weekend: "When we arrived, I found out that it was also my husband's parent's anniversary. When I confronted my husband and asked why he made such a fuss over his parents and ignored me, he said that parents come first. The narcissist may have responded that his parents are "special" and are entitled to be honored, whereas the OCD may have responded, "loyalty to parents trumped the wife's feelings.

In Japan, feelings of power and envy are not a function of the individual but belong to and are embedded in the collective members of the group. Within the group, it is common for women to be subservient and compliant to men.

Women's role is to please and humor men, to help alleviate the stress from their intense jobs. In the privacy of the home, the woman has the power to dominate her husband only in matters that relate to finances and child-rearing.

Role of Women

Not all shamehonor cultures handle aggression, rage, violence, and trauma in the same way (Kobrin & Lachkar, 2011). As therapists, we need to be aware of how various cultures deal with women.

The chaos and violence we sometimes see in sectors of the Arab population stand in sharp contrast to the stoicism of the Japanese, who go to great lengths to maintain harmony or *wa*—the desire to be devoid of conflict and envy. This is apparent in the regard for orderliness and

tranquility in their houses, gardens, and shrines. The group seeks to maintain synchronicity by avoiding conflict even under the direst circumstances. The Japanese are able to keep their cool after major disasters and are masters at containing their envy. Moreover, they believe that one should not show that he has more than the other.

The Case of Nancy and Sharof

While visiting his family in the United States, Sharof, a computer specialist from Iran, met his wife, Nancy, at a restaurant, where she was a cocktail waitress. This case represents the conflicts that ensue as the couple wrestles with the issue of hierarchy in their relationship and the intrusions of his family. The therapist

attempts to open the therapeutic space through couple transference.

Th: Salam. (Therapist greets the couple in Arabic and starts to shake hands, but notices that Sharof pulls his hand away and makes no eye contact.)

S: Salam.

Th: Please have a seat, and we shall begin. I would like to hear from each of you. Who would like to start?

N: I will start.

S: No, I will start.

Th: Very well.

S: My wife does not understand that in our culture women must show obedience to their husband and respect to his family. Family is of the most importance. She must learn that when my mother needs me I must

go, but she gets upset when she remains at home.

N: Upset isn't the word. I go ballistic! He's not telling the whole story. We decided to go to Paris and Morocco for a vacation, and he insists on bringing his mother and his aunt.

S: My first allegiance is to my mother, and in my country the wife understands this. I have been trying to explain this to her, but she doesn't get it.

Th: But things are different in our country. Here men treat their women with respect and as equals.

S: I understand that. But Nancy knew how it is with my mother when she married me.

N: No, I certainly did not! And how did I know that when I did not "obey" your commands you would beat me?

Th: Is this true?

S: Yes, that is my right. And you know what she did? She called the police.

Th: And what did they do?

S: They put me on probation and said if this happens again they will send me to anger management. What they don't understand is it is not anger. It is our right as men. (starts to recite the Koran) Allah says admonish them first, and then beat them.

Th: So you feel it is your right to beat your wife?

S: Not only is it my right, but it is also my duty.

Th: Your "duty" can put you in prison.

N: See what I have to live with? And now he wants to drag his mother and aunt with us on our vacation.

S: My mother and aunt have no one. I am like a protector for them. They are

alone.

Th: Sharof, have you ever considered finding them a support group or helping them expand their social life?

S: Support group! You got to be joking. In our country family is the support group. You just don't understand. You are an American and have no clue where I come from.

Th: But you also are aware that your family don't require the same type of love, intimacy, and dependency as an intimate relationship requires.

S: I can't stand when she gets all emotional, cries, demands!

N: That's exactly right on. He drives me to that point where I lose control.

Th: I am impressed that you are here, Sharof, and that you would choose an American therapist, one that

specializes in marital relations and a Jewish one at that! There must be some part of you that does want to adapt to our way of life (opening up the couple transference and the cross-cultural hook).

N: Good point. Why would he choose you or me?

Th: Yes, Sharof, you could have married a Muslim woman and chosen a Muslim therapist.

S: I happen to like American women. I find them very attractive and sexy.

N: You should see his porno sites (laughs a bit to break the tension).

Th: As much as you find "us" attractive" and lust after us, you must destroy us because you cannot allow yourself to need us or be dependent.

S: (looking toward Nancy) What is she talking about?

N: She is right. You cannot allow yourself to depend on any woman except your mother! Tradition? Baloney! He acts like a believer, a true and faithful Muslim, but he steps out of his tradition when it suits him. Even in his own country he would drink, not pray, eat pork. Yet when it comes to me, he suddenly becomes a devout Muslim (therapist didn't have to find the cross-cultural hook; Nancy did it for her).

Th: Nancy, you are finding contradictions in Sharof's behavior?

S: Hold on! I did not come here for you to shame or dishonor me.

Th: What you call shame, I find very helpful because it allows us to understand that behind your "traditional" flag waving is a very healthy, normal man who would like to be freer to express himself, to love, to be

vulnerable. I think you both did an excellent job in helping me understand not only your cultural differences but how underneath all this you are two people with real and legitimate needs. Can we meet next week at this time?

S: I guess so. As long as you wear a burka.

Th: (laughs) I see you have not lost your sense of humor.

N: Great! See you then.

S: (looking therapist in the eye) Salam!

Th: Salam!

Discussion

In this case, the therapist uses the language of dialectics to show the conflict between the couple's real needs. Under the guise of religion, Sharof hides his dependency needs and

vulnerabilities. His choosing an American wife and an American therapist shows the split part of himself: one part that desires, loves, and needs his wife, and the other part that he rejects. In psychodynamic terms, one could say the good breast that is needed is also the breast that must be destroyed (Kleinian envy). The therapist didn't have to work very hard to find the cross-cultural hook as Nancy confronted head on the contradiction in Sharof's devotion to "tradition." The therapist then used the cross-cultural hook to show empathy with the difficulty of adapting and adjusting to another culture.

However, the therapist had to curtail her own countertransference issues—her rage toward Sharof when he said it was okay to be abusive to his wife and his nonchalant attitude about

imposing his mother and aunt on their vacation. In terms of the domestic violence, she had an obligation to inform Sharof that in our country it is a criminal offense and he could go to jail, even though in his country it is acceptable. Mirroring the conflicts and using the language of empathology and dialectics were most effective in this case. The therapist cautiously offered empathy around the struggles of adaptation as well as the splitting parts of Sharof, while also advising him that cultural traditions and religious laws can never be used as a rationale for abuse, violence, and the mistreatment of women.

Summary

Therapists cannot ignore the cultural, ethical, and religious aspects of therapy. In treating

couples from various cultures, we deal with societies that identify with destructive leaders, endless pain, sacrifice, and victimization. These are societies that do not stress separation from the maternal object but instead maintain a lasting bond in a maternal fusion. The dilemma faced by many therapists when treating cross-cultural couples is that they may not be sufficiently knowledgeable. However, the therapist need only be familiar with some basic customs and traditions to effectively analyze the role culture plays in strained relations between cross-cultural partners so that the healing process can begin.

Self-psychology appears to be the most effective treatment modality in cross-cultural therapy. It offers mirroring and empathic responses designed to scale nearly impermeable

walls of defense and object relations to contain and deal with the aggressive and destructive aspects of the relationship. The grandiose self of the narcissist pompously purports that his or her ways are best. How do we discover a self within the cultural narcissist who comes from a shame society and does not exist outside the context of the group? It is important for the therapist to probe deeply enough to find pathology within the individual, and discover the vertex where conflict exists within his or her own culture.

Important Points for Cross-Cultural Couple Treatment

Learn the fundamental dynamics of the culture; mirror and reflect.

Self-psychology provides the most effective method to mirror and understand the subjective experience (mirroring, empathic attunement, listening, reflecting, empathy toward the conflict

and the vulnerability but not toward the aggression).

Know something about the foods, holidays, and traditions of the patient. Learn a few words of the patient's language—at least hello and goodbye.

Be empathic to the cultural differences, not to the aggression.

Be aware of the differences between the individual and group self.

Be aware of special treatment needs. Try to bond through some common ground (e.g., music, food, dance): for example, "I love Arabic music," or "I would love to learn how to make couscous" or "I have eaten Korean food and love Kimchi!"

Be aware of body language—for example, with Asians, keep your distance; with Persians and Italians, stay close.

Find pathology/contradiction) within the individual.

Find pathology (contradiction) within the culture.

Find pathology within the government.

Remind the couple why they are in treatment.

Mirror the conflict; don't try to fix it.

Use the cultural contrast hook (find contradiction in culture and individual)

Use humor and play to avoid sounding punitive. Many cross-cultural patients come from countries where their human rights have been violated by governments: "What would happen if I showed up in your country de-veiled or pregnant out of wedlock?"

Keep in mind that many people from other cultures are consumed by persecutory anxieties. It is important to speak in a calm and caring manner

Chapter 7

Courts Beware: The Obsessive-Compulsive and Other High-Conflict Personalities[1]

Suddenly my head begins to spin. I feel dizzy and confused. My head keeps going round and round. In front of me sits a married couple; they go on and on in circles, going nowhere. A feeling of despair overwhelms me as I think to myself, "This couple needs to be in therapy." And then realize l am the therapist!

Joan Lachkar, *Narcissistic Borderline Couples: Implications for Meditation*

Happy families are all alike; every unhappy family is unhappy in its own

way.

Leo Tolstoy, *Anna Karenina*

Nothing is as highly emotionally charged as couples going through divorce and custody battles. When couples divorce little do they know of the horrors that await them. Emotions are high. Lies, false accusations of child abuse/molestation, forgery, purposeful building of huge legal fees, unwarranted restraining orders, out-of-control behavior in front of children are some of the behaviors that an OCPD starts to exhibit when legal mediation begins. As children, those with OCPD often take their place as "little adults" and act as intermediaries in their parent's marital disputes. Often these children are made into "mini-mediators," who are forced by circumstances to

grow up much too early because they feel responsible for their parent's divorce.

In recent years, an increasing number of mediators, lawyers, and court officials have consulted extensively with clinicians and other mental health professionals in dealing with couples with personality disorders—also known as "impossible couples." These are individuals who are dominated by primitive defenses and exhibit highly volatile behaviors. In many of my other publications, I refer to the highly charged emotional reactions marital conflict elicits as "V-spots," through which each partner stirs up some highly charged unresolved archaic injury in the other (Lachkar, 2008a, 2008b, 2009, 2011, 2013).

The more he asks for more time before settling, the more I become a raging

maniac.

Many practitioners treat patients who are experiencing difficulties with high-conflict people in legal disputes. Narcissistic and borderline partners of the OCPD present special difficulties in legal mediation. A person with a narcissistic personality will fight to the end to prove they are special and are entitled. Those with borderline personality disorder also will fight to the bitter end, even to the extent of sacrificing self and others (spouse, children, family, career, reputation) until they achieve their final goal—revenge. Therapists and legal officials are continually perplexed as to why people continue to battle without ever reaching conflict resolution. On the surface, couple problems seem to revolve around children, sex, money, commitment, work, outside intrusions

(ex-spouses, in-laws, friends, sports, pets, hobbies). But the underlying issues are more about control, domination, envy, jealousy, shame, guilt, submission, victimization, and oedipal rivals.

Over the years, my focus has been on the dynamics of narcissistic and borderline personality disorder within the courts system, which has gained attention in the field of divorce and custody litigation. For example, Marsha Linehan (1993) the pioneer of Dialectic Behavioral Therapy (DBT), implies that even when conflict resolution is reached or offered to the malignant borderline, it is repudiated. Let us take a moment to note the differences between mediation and couple therapy.

Difference Between Mediation and Couple Therapy

Mediation has become a common and alternative attempt to resolve domestic disputes (divorce, child custody, and visitation) in lieu of court involvement. Some court systems require mediation as mandatory in an attempt to help partners come to terms with disagreements and find ways to reach conflict resolution without causing either emotional or physical harm to themselves or their partners.

Mediation is a task-oriented method to alleviate disputes through negotiation and reach conflict resolution. This means that decisions are not based on how one "feels" but are more about the "needs" of the family. Past experiences such as early childhood trauma, attachment disorders,

and family conflicts do not matter. Mediation is guided by a group of trained lawyers and mediators that are by law involved in the decision-making process. Reaching resolution is not based on a person's past, personality defects, or traumatic experience; it's more about who is most qualified to care for the child if equal time-sharing for custody agreement is not met. In fact, it does its best to break through the defenses to allow the raw self or true self to emerge (Lachkar, 2016).

> *As mediators, we really don't care so much about your feelings and the importance of your attachment to your possessions and objects. Our job to follow the law and recognize the law and legal rights regarding community property.*

Couple therapy provides a more in-depth approach to working through the couple conflicts and disagreements. It takes into account such matters as family conflict, childhood trauma, and attachment disorders. Couple therapy is an experience that occurs among three persons. I coined the term "couple transference" (Lachkar 2004, 2007, 2008a, 2012, 2013, 2014) to show how the couple projects onto the therapist. The deeply emotional experience of intense communication and feelings that therapy entails begins with acknowledging the profound challenges of a primitive relationship and matures into the awareness of healthy dependency needs and mutual respect. The couple presents its own dramatic narrative, and with each session the curtain opens on the opportunity to create a new experience. Unlike

mediation, couple therapy does not have a group of laws to back it up. You can't say, for instance, "Well, there is a law that says you must take your wife out for Valentine's Day and buy her flowers!" The experience is more subjective, and the needs of the couple gradually unfold as therapy continues. Couple therapy can be long or short term, whereas mediation is designed to be brief.

A borderline patient disclosed that she loves the court system. Her entire life people have been against her. The court allows her to feel safe and protected.

> *Now I have a family court that listens to me, defends me, and treats me like a human being. Unlike my OCPD husband, who turns his head away each time I speak. If my OCPD husband doesn't listen to me, the judge will!*

In recent years, narcissistic, borderline, and OCPD personality disorders have gained attention, especially in the field of divorce and custody litigation. The OCPD's unleashed aggression, accompanied by anal retentiveness and withholding tendencies means that sabotage, vengeance, and retaliation disrupt any potential for resolution. Instead, it is replaced by a pervasive shame/blame and attack mentality. Even when conflict resolution is reached or offered to these high-conflict personalities, it is repudiated.

Implications for Mediation

This chapter focuses on the court system and the stresses and strains put on the court when it must deal with the excessive demands of the OCPD. Although I am not a divorce lawyer, I

have consulted with many experts in the field of family law. Many practitioners treat patients who are experiencing difficulties with OCPD partners in legal mediation and court custody. A person with OCPD will fight to the bitter end, even to the extent of sacrificing self and others (spouse, children, family, career, reputation) until they achieve their final goal. Therapists and legal officials are continually perplexed as to why people continue their never-ending battle without ever reaching conflict resolution.

Personality Disorders and Family Court Litigation

People with personality disorders usually experience chronic internal chaos and distress (fear of abandonment, as well as unwarranted issues around betrayal, and trust) and exhibit self-sabotaging behavior. They are dominated by

such issues as rage, envy, lack of impulse control, unleashed aggression, an excessive need to control/dominate, and unresolved oedipal issues. These predominant conflicts place extreme pressure on marriages and children and can lead to the most contentious divorces.

One prevalent personality disorder in divorce hearings is notably the OCPD personality. On the surface they appear normal; many are intelligent, high-functioning professionals, and present a very attractive personality. But lurking in the shadows is an uncontrollable impulse to destroy, threaten, and sabotage. Their many hidden primitive and unconscious defenses surface in the divorce process when their sense of power and control is being compromised. In order to save face or attempt to regain control,

those with OCPD are more likely to make false statements, distort the facts, and make false allegations. In some cases, they convince themselves to believe that their lies are the truth.

Most commonly, they are characterized by their bullying, tormenting, aggressive, controlling, sadistic, and domineering acts. These acts can fluctuate from intense rage and bullying to victimization. Furthermore, those with OCPD are the ones who tie up the court systems with endless complaints and declarations—not for the purpose of reaching resolution but to destroy the person who they perceive has betrayed them. Because of childhood abuse, trauma, or neglectful bonding experiences, they grow up perceiving the world as a dangerous and frightening place.

Unfortunately, they find attorneys who collude with their pathology. The OCPD also crosses over with the antisocial, who has little regard for rules and authority, lacks empathy and conscience, and has no regard for the impact their destructive behavior has on others.

Another common personality found in the courts is the narcissist, who suffers from excessive entitlement fantasies and has a belief system based on feeling superior to others. One thing they all share is the lack of rational thought, logic, and reasoning. Because of their severe defense mechanisms, they exhibit what I refer to as ego dysfunctionality. With their altered sense of perception, they view the world through distorted lenses. In some cases, they are delusional, which constitutes their rationale for

lies, deception, and false accusations. Collectively, they lack the filter between id and superego functioning that tells right from wrong. For example, it is wrong to falsely accuse one's spouse of child abuse in the hopes he will lose his job, or to go around bad-mouthing one's spouse to children or others.

Within the complexity of the relationships of those with personality disorders, one can readily see how court systems can become perplexed and preoccupied with trying to understand how to deal with the various types of oppositional couples. Even when apart, separated, or divorced, such couples maintain a tie or a bond, albeit a parasitic and abusive/destructive bond that never allows the partners to reach a final resolution. The most striking feature of this

unconscious parasitic or traumatic bonding is a clinging kind of dependency that differs dramatically from a healthy dependency.

In many of my publications, I have referred to these kinds of painful attachments, most specifically for the borderline, whose desire to remain forever bonded or connected is a more pervasive force than life itself (Dutton & Panter, 1981, Lachkar, 1998a, 2004b). For the borderline, it is preferable to stir up highly charged feelings, to repeat the same trauma again and again. "Better to feel or induce pain rather than face an empty, impoverished internal world." In unspoken language, the borderline communicates his/her disappointment with an archaic, empty mother, projecting onto the narcissistic partner the fantasized mother

capable of making up for all the early losses. Through blaming and attacking mechanisms, they express disappointment that the other has failed to provide a "holding environment" (Winnicott, 1958) and to be the all-encompassing available mother preoccupied with her "child/husband." When this fantasized holding environment is threatened (as in divorce), an intense fear ensues, along with the desire to "get back," to retaliate. Revenge and getting even then becomes the pervasive force governing behavior. This explains why court officials are puzzled and fail to understand why children are often placed in the middle of arguments, are deprived, made to be "go-betweens," and forced to become little adults and play the role of mediators, "saviors/messiahs" (Lachkar, 1983,1984, 2016).

My concept of the V-spot has applicability in court proceedings dealing with divorce that involve those with OCPD, who share many attributes of what I refer to as "household terrorists" or court terrorists."

A Fantasy Sketch

What follows is a fantasy sketch of how a mediator might confront these three personality disorders.

The Narcissistic Wife

Narcissist: I don't understand why you are giving us 50/50 when I am the primary caretaker. My husband has had endless affairs. He is an OCD works long hours never home. Our children will probably be with the nanny and not have adequate parental care. I feel that I should get 100% custody because with all the

stress he has put me through I feel entitled.

Mediator: After evaluating the situation we have reached the conclusion that emotionally, financially and psychologically shared custody is best for the children.

Narcissist: No! No! Not acceptable.

Mediator: You still have the option to open the case or not this is what stands. The issues you brought up earlier are things to work through with your therapy, maybe conjoint therapy and co-parenting classes.

The Borderline Husband

Wife: I don't understand why you are giving us 50/50. Don't you get it. He could care less about the kids and is more concerned about attacking me, revenge retaliation and getting even. He feels so abandoned he will spend

the rest of his life making my life miserable. He should not even be around the kids he could care less about them.

Mediator: These are issues to bring up with your therapist, for now we find no evidence to deny him custody. Your therapist can help you with conjoint and co-parenting. If not satisfied, you can always re-open the case.

The Obsessive-Compulsive Husband

Wife: I don't understand why you are giving us 50/50 custody. Don't you see what he put us through in court. This is what he does with me and nothing is perfect enough. Endless revisions and nothing satisfies him. He's paranoid about every document and has to examine again and again and assumes the words are out to get him. He drives me and our kids crazy.

Mediator: We still see no reason why you should get more custody. Both of you seem adequate. Meanwhile the court suggests you both seek therapy, conjoint and co-parenting

OCD Wife: This is not acceptable

Mediator: For now our decision is what stands. You can always reopen the case. You have already spent endless hours reading your husband's documents and revisions.

Court Theatrics

This chapter would not be complete without noting the case of Amber Heard vs. Johnny Depp (LA Times 2022). This case has received more notoriety in the media overshadowing some of the world's most serious matters (wars, inflation, lack of baby formula, Viruses). But given the media storm surrounding the trial,

personality disorders and their influence on the courts have been given a higher profile.

An outcome of my published book *The Many Faces of Abuse the Emotional Abuse of High Functioning Women* was followed by several versions of "Courts Beware" in many other published books. The notoriety of the case of Amber Heard and Johnny Depp has brought forth a personality disorder which has not received much recognition— the borderline personality disorder (BPD). How do we diagnose people who are not on our clinical couches? Amber's tears seem like Crocodile tears! Real or fake? Narcissism has become a household term partially because everyone knows when they meet one; all they do is talk about themselves. Borderline personality

disorder, on the other hand, is rarely explained nor are simple examples portrayed to the general public. The term was used in the court hearing of John C. Depp, II v. Amber Laura Heard, when Shannon Curry, PsyD, a clinical forensic psychologist testified Amber Heard allegedly was a borderline histrionic. The notoriety of the trial and it's participants has brought forth more media attention to borderline personality previously much neglected. One distinction between the narcissist and the borderline is the narcissist will spend the rest of their lives trying to prove they have a special sense of existence, whereas the borderline couldn't care less about specialness but is absorbed with trying to prove they exist as a thing in itself. "I'll do anything just don't abandoned me!" Patients with high-conflict personalities are typically narcissistic,

borderline, and/or sociopaths. These personalities are master manipulators. Their most prevalent characteristics are the refusal to cooperate, being deviant, playing the victim card and often spending the rest of their lives retaliating, getting even, and revenging. They work to get even at the expense of their children, money, and even their own self.

> *And now he doesn't help pay for our daughter's college education because he's a hoarder, stubborn, and very withholding.*

Where Do Psychology and Mediation Meet?

More and more mediators stuck in the quagmire created by these beleaguered couples and their antagonistic types of relationships are becoming increasingly aware of the importance of understanding various personality types. For

example, someone with a narcissistic personality will be more concerned with possessions, feel entitled to have it all (the custody, the money, the house, the furniture, the pets) compared to the borderline, who could care less about possessions but is all about revenge and spending the rest of their life retaliating, getting back at the spouse or "bad mommy" whom they perceive has abandoned or betrayed them.

Family court has an advantage over therapists in that there is a powerful authority figure, the judge, who calls the shots regardless of the mental state of those involved. The focus is not about how one or more parties *feels* but more about law and what is best for the family. The courts do, however, have the authority to order counseling for parents, especially if there

is a potential threat or danger to the best interests of the child.

Summary

Judges, attorneys, mediators, and other court officials need to be more aware of various personality disorders and their defenses to allow the true personalities of the couple involved in divorces or child-custody cases to be revealed. A well-trained judge or mediator can see right through the lies, manipulation, and false claims made by those who, under the guise of caring, can act out the most heinous revenge against a spouse in family court. The focus is more on negotiation and solution than on shame/blame/attack and revenge. The court should not assume both partners are "offenders," but recognize the one with a personality disorder

might need more discipline and allow authorities, rather than primitive defenses, to rule the proceedings. The court should order further sanctions for those who file unnecessary claims and escalate mediation and court costs for the sole purpose of depleting their partner financially and emotionally. In addition, when courts are faced with are multicultural couples, the individuals bring to the courtroom their national flag along with rituals, ideology, religion, their view of women and child rearing practices. Being aware of cultural conflicts adds another level of complication. When correctly informed, the courts have the power to use their authority in a most constructive and productive way to see that family justice is truly served.

Note

[←1] Portions of this chapter were in papers presented at the Winter Conference of the Association of Family and Conciliation Courts (AFCC) on December 13, 1985 in San Diego, CA and at the AFCC 53rd Annual Conference, Modern Families: New Challenges, New Solutions, June 1–4, 2016, Sheraton Seattle Hotel, Seattle, WA. The paper was originally published in *Conciliation Court Review*, June 1986, pp. 31-43.

Chapter 8

The Obsessive in the Workplace

Over the years, I have treated numerous patients working in large corporations who complain of abuse, mistreatment, humiliation, and degradation. One wonders how an entire group, institution, university, or corporation joins together in collusive bonds and mistreats those who do good work and devalue and abuse them. In a previous chapter, we saw how people in various cultures bond together to act out in unison their unconscious collective group fantasies. These same group myths can be acted out at the corporate level. What is it like to work under a narcissistic boss, an OCPD boss, a

borderline boss? It might feel something like the following:

> *I worked with this company for fifteen years. I am now 60 years old. This job required a great deal of skill, experience, and scientific knowledge. As a sales representative, I was responsible for handling all the medical supplies and equipment. I was hired on the spot for my knowledge and good interpersonal skills and for my stellar references, with a guarantee of a promotion and increase in salary. My company got reorganized and with this came a new boss. Misfortune came when my old boss, who hired me, was replaced with a stiletto-wearing young boss. This was when everything changed. Dora was the quintessential avant-garde executive who wanted not only everything to be perfect but to look perfect. She criticized how I dressed and how I did my hair. And whatever*

work I did was never enough. Ominous feelings came over me when she excluded me from meetings and lunches, made no response to my emails, and started to hire other people to do my job. I felt very left out and isolated. It was clear that she wanted younger people who could live up to her obsessive demands. When I complained to human resources about my mistreatment, my boss denied the allegations, "Oh, I didn't mean to exclude her; that must have been an oversight by my secretary!" Because I was older and did not dress in modern suits and stiletto heels, I was treated as an outcast for not fitting into her perfect image.

Collectively speaking, people who work in corporations and institutions sometimes use the workplace as a platform to act out regressed primitive defenses, targeting scapegoats on

which to project their defective selves. The area of employee complaints still has not been clearly defined in the legal system or in the business world itself. There is little consensus on the rights of employees, how they can best present their complaints, and the consequences of their complaining. Some employees can even get fired for voicing their complaints, despite their legitimacy.

Unfortunately, as it now stands, emotional abuse in the workplace does not constitute grounds for legal action. Even if it did, it would be hard to prove. Many patients who experience "corporate abuse" come into treatment puzzled and baffled that a person with their pristine record and long-term commitment to their employer can be mistreated or terminated. Many

have recognized the danger signs of abuse or at least had an inkling that something was amiss, but the behaviors were too covert and subtle to justify their filing a formal complaint.

The Case of Melissa

Melissa is an attractive woman in her mid-fifties, who worked for a female head nurse in a large hospital. Her feeling that something was wrong grew steadily. She entered treatment very distraught, complaining of being abused by the head nurse. At meetings, her boss would dismiss her ideas without giving them any consideration and even would cut her off in mid-sentence. Melissa started to hear about meetings and social events to which she was not invited. Although she felt it coming, the hospital management never came straight out and said it opposed her

being a lesbian; rather, it enacted its dismay in the most insidious ways.

> *Sure enough, they fired me when I announced that my lesbian partner and I were going to have a baby. I knew this was a Catholic hospital and management was morally opposed to gay marriages and partnerships, but I never would have imagined in this day and age that there would be such discrimination. Even worse, the staff—including the doctors, nurses, and administrators—all gave me "the look," the cold shoulder. At first, I thought I was imagining it, but after a while I realized that I was being ostracized increasingly, shut out of staff meetings, and not included in social events. I then contacted human resources.*

What confused Melissa was that she was greatly respected by the patients. She was

always attentive and went out of her way to check their charts to ensure everything was in order. Many visiting doctors respected her. If Melissa had a problem, it was that she was too efficient and attentive. However, management finally fired her for "negligence." All the while Melissa knew she was not only being scapegoated but that she had been set up to appear negligent. She was blamed for many of the complaints and hospital violations that were not being attended to. She was shocked how after ten years of employment, with a record of hard work and impeccable ethics, she could be dismissed so abruptly.

Melissa's case shows that no matter how efficient and effective an employee is, issues unrelated to work (in this instance Melissa's

"gayness") can become more pervasive than job performance. When Melissa contacted an attorney, she was told, as expected, that there was no substantial evidence that could constitute proof of unjustified dismissal.

Red Flags of Workplace Abuse

Good workers who fall within the matrix of the corporate abuse system complain of consistently being criticized, having their job responsibilities taken away, and being assigned meaningless, makeshift tasks or "busy work" to perform on a daily basis. Some of these employees are given nothing to do at all and then written up for poor performance. The bully boss is obvious. However, not all workplace abuse involves the boss who is constantly on an employee's back. There is also the silent bully

boss who ignores and avoids. Here are some of the signs of a bully boss and an abusive work situation:

A boss who constantly yells at workers and picks on the same people in front of others or acts in a threatening or dismissive manner when there are no witnesses.

A boss or powerful person who seeks out a scapegoat, thereby inviting others who are eager to make sure the boss is aware of their "loyalty" to project their frustrations onto this person as well.

A boss who constantly blocks someone's promotions, doesn't listen to requests, or repeatedly puts one on hold.

A boss and coworkers who give an employee senseless, meaningless busy work, meant to undermine the employee's performance and make him or her feel worthless and unneeded.

A boss who heaps constant bullying and abuse, both overt and covert, on an employee.

A supervisor who sabotages an employee's good work or claims it as his own.

A boss, supervisor, or coworkers who deliberately ignore certain individuals at work and make sure that they are kept "out of the loop."

A supervisor who overloads employees with work, sets unreasonable deadlines, and requires many hours of overtime work without additional pay. (Note: If, despite the long hours, the average wage dips below the federal minimum wage, legal action is allowable.)

A supervisor who attacks a worker personally and calls him names.

A boss, supervisor, or coworker who makes jokes about an employee.

A boss or supervisor who consistently gives an employee equipment that does not function properly, such as the oldest computer in the building or a faulty printer.

A boss who places an employee in dangerous positions—for example, at a front desk area that

recently has been the scene of an armed robbery —without initiating adequate security measures.

A boss who puts an employee in a workplace area that does not have adequate heating, cooling, and ventilation.

A boss or coworkers who consistently tell an employee that the empty seat next to them is taken, with the result that the employee ends up sitting alone in the back or must get a chair from another room, thus always feeling like the one left out.

Department members who e-mail everyone about where they are going for lunch or tell others that there is a celebration for a coworker's birthday except for the victim of their abuse, whom they deliberately want to exclude and embarrass.

Reverse Superego

The healthy superego is the voice of morality, providing the basic guidelines that help the child distinguish between right and wrong. The reverse superego is a term I originated to

describe what happens to a child who, despite doing good deeds, gets punished instead of praised (Lachkar, 2008a, 2008c). The reverse superego is the result of inhibited development of a healthy superego. It creates ambivalence and confusion so that the child has trouble recognizing good from bad, right from wrong, and deserving from not deserving. In the corporate world, the same can hold true for excellent workers who do not get the awards and recognition they deserve, while others whose work is inferior are rewarded. As one disillusioned and disappointed worker explained:

> *Whatever I do at my job, it is never good enough. I am actually being punished for finding typos in some of the executives' reports. It is so crazy-making because that is the very reason*

I was hired. They are all so worried I will shame them. Now I feel very anxious and shaky. I am not myself and have migraine headaches. When I walk into a room, I stumble. I have no confidence and feel as though I am constantly walking on eggshells. I am becoming forgetful and am starting to doubt myself. I keep having to check on work I have done and retracing my steps to make sure I'm not doing something wrong. It is never clear what my role is. I was supposed to be an executive assistant administrator. Instead, I spend half my time running errands, doing perfunctory things like picking up packages from the supply room. Often I am told that the package I was sent to retrieve was already picked up, like my bosses are sending me on a fool's errand. I am afraid to confront my bosses, fearful of getting them pissed at me or losing my job. When I fix everyone's typos, find ways

to streamline procedures, or determine areas where we can save money, instead of getting a thank-you, my bosses give me a dirty look as though to say, "Who do you think you are?" Yet, I have saved them thousands upon thousands of dollars

The Queen Bee Syndrome

A new syndrome has been emerging in the workplace. The Queen Bee (Drexler, 2013) is an alpha female who will go to great lengths to maintain control and power. She's the distaff equivalent of the King Bee boss, who has long reigned over the corporate kingdom. The Queen Bee treats all subordinates critically, but females bear the brunt of her abuse. She is the prototypical female bully. I would speculate that the Queen Bee is often extremely narcissistic and is only out to accomplish her self-serving

purposes, using childish tactics to keep other females from advancing. The Queen Bee is also OCD. This can take the shape of someone being obsessed with one's dress, performance level, neatness, and grooming (see case below). These are the women who oppose the rise of other females because they are obsessed with attaining dominance and authority and fearful of anyone who can surpass them in ability or popularity. They need to prove they can do the job just as well as males can. It has been found that women who achieve success in male-dominated environments are more inclined to oppose the rise of other women (Lachkar, 2014). Oftentimes, the OCPD will distort reality for their own self-serving purposes.

> *Mary felt that because she was younger, more attractive, and more competent,*

her Queen Bee boss envied her and was constantly on her back. Susan recalls how she showed up at work wearing a new outfit for a performance appraisal session with her boss, who commented, "Oh, here you are asking for a raise and you keep buying new clothes! Who are you trying to impress?"

The Case of Mr. Frank

Mr. Frank came into the therapist's office carrying two bulging legal-size briefcases. As he sat down, he said he might need a double session. He had been stifling his feelings for years and never told anyone about the kind of abuse he was getting at the $100 million corporation at which he worked. After years of loyal service and after raising more than $8 million for the company, he had asked for a raise. The King Bee's response was, "What for?

You didn't do anything. All that money came from my efforts." At that point, Mr. Frank opened his briefcases, revealing piles of article clippings from magazines and newspapers, and other promotional materials he had created for the company as part of his money-raising efforts.

> *I need time off. I work endless hours for my boss and am always on call for his numerous complaints and constant demands. He is so cheap he refuses to buy me a new computer and printer. He doesn't say a word when I bring in money or a new client; then, when things are slow he blames me. My wife is ready to divorce me. We need to put a down payment on another house so I can live closer to work and shorten my two-hour commute every day. But my boss doesn't give me any credit for all the work I do on his behalf. To him I'm a nobody.*

The previous cases in this chapter are examples of employees who are good, resourceful, entrepreneurial, and yet get punished by their Queen and King Bee bosses. It is difficult when a hard-working employee—whether it be in corporate America, an institution, a governmental agency, or a hair salon—comes to therapy with a complaint of workplace abuse. We can't control the abuse and aggression, but we can help our patients learn not to identify with the mistreatment from the bad boss/parent who never offered praise or reward for being good and dutiful when growing up.

> *My boss reminds me of my mother. Whatever I do is not good enough. I was a very dutiful child, just as I am a very dutiful employee. Whenever I got good grades, cleaned my room, took*

care of my younger siblings, I got a tongue-lashing. Most kids get rewarded. My mother would always grumble that I wasn't doing enough, wasn't good enough, and had no right to complain; instead I should count my blessings for having a roof over my head. Here I am, an assistant department manager who works long hours and does more than is expected. Instead of being appreciated and invited to sit in on the management meetings, I get only criticism and put-downs. My boss neglects me, never praises me, leaves me out of meetings where I might get any credit, and treats me as if I am invisible. I can't sleep; I have nightmares and wake up every morning with terrible headaches.

To this the therapist can respond:

Anybody would have the same reaction. No mother, caretaker, or boss has the right to mistreat and neglect a child or

an employee. Given your background of emotional abuse, one can understand how there can be a tendency to identify or over identify with the "bad boss/mother," but you must be careful not to personalize this. All you can do is what you have been doing. Try to stay focused. You need to know that in spite of what your boss says or how he treats you, you are doing a good job!

In the previous vignette, note that the therapist does not advise the patient to quit his job. As long as these primitive defenses mechanisms are operative, it is not a good time to make major decisions about one's career or lifestyle because ego dysfunctionality can impair the capacity to think rationally.

Summary

This chapter illustrates that good workers and smart people can become of victims of abusive bosses. Part of understanding the abuse that occurs in the corporate world involves group psychology, which explains what happens when other workers band together in complicity with destructive bosses. This chapter was based on Bion's concept of two kinds of groups: the task-oriented work group and the regressed group. The latter group dwells in a toxic environment where primitive defenses take over and the group's goals and purposes become contaminated by such primitive defenses as control, domination, envy, jealousy, victimization, subordination, and oedipal rivalry. These primitive defenses become the

replacement for "getting the job done," causing workers to lose focus of their goals. Why are good workers often punished and the bad ones praised? I use my concept of the reverse superego to explain why bad becomes "good" and good becomes "bad"—a corporate Mad Hatter's Tea Party. In situations where these kinds of groups are involved, many corporations or institutions aren't set up to listen to and follow through on legitimate complaints and instead turn the complaint against the complainer.

Final Thoughts

Communication with people with high-conflict personalities is not simple. My intention in this volume has been to encourage therapists and partners of various personalities to address in a new way the complicated issues involved in communicating effectively with an obsessive compulsive personality and other forms of personality disorders. My concept of the V-spot has been reintroduced to help therapists and patients identify the epicenter of emotional vulnerability. This concept, and the unique Language of Empathology and Language of Dialectics that I originated to foster more effective communication. are an outgrowth of many years of development. As a therapist,

particularly a couple's therapist. I have found that these approaches have applicability to today's environment, including global concerns. Just as partners we treat in clinical practice have their own specific V-spot, so do countries and nations.

So, as the curtain closes, let me say that I hope this book has revealed a new perspective and has fostered a greater understanding of what it takes to open up crucial channels of communication and to keep them flowing freely. This book has been written with great respect for the cast of characters involved and with much hope that it will promote heightened awareness of the need for sensitive, thoughtful communication that leads to healthy, intimate, loving, lasting relationships.

About the Author

Joan Lachkar, PhD, is a licensed marriage and family therapist in private practice in Encino, California. She is an affiliate member of the New Center for Psychoanalysis, and author of *The Narcissistic/Borderline Couple*, *How to Talk to a Narcissist*, *How to Talk to a Borderline*, *The V-Spot*, *The Disappearing Male*, *New Approaches to Marital Therapy,* and *Common*

Complaints in Couple Therapy, as well as this volume. Dr. Lachkar is also a psychohistorian and has published numerous papers and articles on marital and political conflict in the *Journal of Psychohistory, Frontpage,* and *Family Security Matters*, in addition to presenting a paper on "The Psychopathology of Terrorism" at the Rand Corporation. She can be contacted at jlachkar@aol.com.

Glossary

Attunement

Attunement is the rhythm of the heart and soul as it blends with another person. According to Winnicott (1965), it is that beautiful moment of the motherinfant ecstasy of togetherness against the backdrop of dialectic tensions of the dread of separateness. The infant and mother are one in total harmony, bliss, and synchronicity. Whether it involves the dancer and the pianist, the musician and the conductor, the painter and his canvas, or the patient and the analyst, there are two types of attunement to which I refer: (1) experiencing the moment of togetherness, and (2) sensing the rhythm and timing of the other.

Borderline Personality

This personality disorder designates a defect in the maternal attachment bond as an over-concern with the "other." Many have affixed the term "as-if personalities" to borderlines, who tend to subjugate or compromise themselves. They question their sense of existence, suffer from acute abandonment and persecutory anxiety, and tend to merge with others in very painful ways in order to achieve a sense of bonding. Under close scrutiny and stress, they distort, misperceive, have poor impulse control, and turn suddenly against self and others, attacking, blaming, finding fault, and seeking revenge).

Containment

A term employed by Wilfred Bion to describe the interaction between the mother and the

infant. Bion believed all psychological barriers universally dissolve when the mind acts as receiver of communicative content, which the mother does in a state of reverie by using her own alpha function. Containment connotes the capacity to transform the data of emotional experience into meaningful feelings and thoughts. It is based on the mother's capacity to withstand the child's anger, frustrations, and intolerable feelings and behaviors long enough to decode or detoxify them into a more digestible form.

Countertransference

Countertransference refers to a process by which feelings toward a patient become distorted if the patient stirs up some feelings that interfere with the therapist's ability to maintain therapeutic

neutrality. The clinician suddenly develops a personal/emotion—e.g., such as sexual attraction, hatred, envy, disgust— and these feelings can create a negative therapeutic alliance. At this juncture the therapist needs to seek consultation.

Couple Transference

I devised this term to describe what happens during treatment when the couple jointly projects onto the therapist some unconscious fantasy. Couple transference does for the couple what transference does for the individual, but is slightly more complex. *Now you are doing the same thing with me that you do with your husband!* Couple transference interpretations are derived from the analyst's experience and insights, and are designed to produce a

transformation within the dyadic relationship. The couple transference refers to the mutual projections, delusions, distortions, or shared couple fantasies that become displaced onto the therapist. The notion of the "couple/therapist" transference opens up an entirely new therapeutic vista or transitional space in which to work. It is within this space that "real" issues come to life. A borderline husband says to the therapist: *Now you're just like my wife, selfish, greedy, and only caring about yourself.*

Cultural V–Spot

The cultural V-spot is a collectively shared archaic experience from the mythological or historical past that evokes painful thoughts and memories for the group, e.g., burning of the temple, loss of land to Israel, the expulsion of

Ishmael to the desert with his abandoned mother, Hagar.

Depressive Position

This is a term devised by Melanie Klein to describe a state of mourning and sadness in which integration and reparation take place. Not everything is seen in terms of black and white. There is more tolerance, guilt, remorse, self-doubt, frustration, pain, and confusion. In this state, one assumes more responsibility for one's actions. There is the realization of the way things are, not of how things should be. As verbal expression increases, one may feel sadness, but one may also feel a newly regained sense of aliveness.

Dual Projective Identification

Whereas projective identification is a one-way process, dual projective identification is a two-way process that lends itself to conjoint treatment. One partner projects a negative feeling onto the other, who then identifies or over identifies with the negativity being projected. *I'm not stupid! Don't call me stupid!*

Ego

The ego is part of an intrapsychic system responsible for functions such as thinking, reality testing, and judgment. It is the mediator between the id and superego. The function of the ego is to observe the external world, preserving a true picture by eliminating old memory traces left by early impressions and perceptions.

Envy

Klein made a distinction between envy and jealousy. Envy is a part-object function and is not based on love. She considers envy to be the most primitive and fundamental emotion. It exhausts external objects and is destructive in nature. Envy is possessive, controlling, and does not allow outsiders in.

Folie à Deux

In general terms, folie à deux refers to Melanie Klein's notion of projective identification, whereby two people project their delusional fantasies back and forth and engage in a foolish "dance." The partners are wrapped up in a shared delusional fantasy, and each engages and believes in the outrageous scheme of the other. Usually the term applies to both oppositional

and collusive couples. In some cases there is triangulation, a three-part relationship in which two people form a covert or overt bond against another member.

Guilt

Guilt is a higher form of development than shame. Guilt has an internal punishing voice that operates at the level of the superego (an internalized, punitive, harsh parental figure). There are two kinds of guilt: valid guilt and invalid guilt. Valid guilt occurs when the person should feel guilty. Invalid guilt comes from a punitive and persecutory superego.

Internal Objects

Internal objects emanate from the part of the ego that has been introjected. They are part of an intrapsychic process whereby unconscious

fantasies that are felt to be persecutory, threatening, or dangerous are denounced, split off, and projected. Klein believed that the infant internalizes good "objects" or the "good breast." However, if the infant perceives the world as bad and dangerous, the infant internalizes the "bad breast."

Jealousy

Jealousy, a higher form of development than envy, is a whole-object relationship whereby one desires the object but does not seek to destroy it or the oedipal rival (father and siblings, those who take mother away). Jealousy, unlike envy, is a triangular relationship based on love, wherein one desires to be part of or included in the group, family, clan, nation.

Language of Empathology and Language of Dialectics

Both narcissists and borderlines require their own "special" form of communication. This led me to invent "The Language of Empathology" for the narcissist and "The Language of Dialectics" for the borderline. Motivated by the works of Heinz Kohut, Wilfred Bion, and Marsha Linehan, I originated these languages to fulfill the need for empathic understanding for the narcissistic and the splitting mechanism for the borderline and to make communication more "user friendly." Inspired by these theorists, these two languages provide a wider range of therapeutic space, especially in addressing effective communication with eight different kinds of narcissists and the various types of

borderlines, including "The Narcissist the Artist," and the "Cross-Cultural Borderline."

Manic Defenses

The experience of excitement (mania) offsets feelings of despair, loss, anxiety, and vulnerability. Manic defenses evolve as a defense against depressive anxiety, guilt, and loss. They are based on omnipotent denial of psychic reality and object relations characterized by a massive degree of triumph, control, and hostility. Some manic defenses work in the ego.

Mirroring

This is a term devised by Heinz Kohut to describe the "gleam" in a mother's eye, which mirrors the child's exhibitionistic display and the forms of maternal participation in it. Mirroring is a specific response to the child's narcissistic–

exhibitionist displays, confirming the child's self-esteem. Eventually these responses are channeled into more realistic aims.

Narcissistic Personality

Narcissists are dominated by omnipotence, grandiosity, and exhibitionist features. They become strongly invested in others and experience them as self-objects. In order to preserve this "special" relationship with their self-objects (others), they tend to withdraw or isolate themselves by concentrating on perfection and power.

Narcissistic/Borderline Relationship

These two personality types enter into a psychological "dance," in which each partner consciously or unconsciously stirs up highly charged feelings that fulfill early unresolved

conflicts in the other. The revelation is that each partner needs the other to play out his or her own personal relational drama. Engaging in these beleaguered relationships are developmentally arrested people who bring archaic experiences embedded in old sentiments into their current relationships.

Object Relations

Object relations is a theory of how unconscious internal feelings and desires, in dynamic interplay with current interpersonal experience, relate to and interact with others in the external world. This is an approach to understanding intrapsychic and internal conflict in patients, including projections, introjections, fantasies, distortion, delusions, and split-off aspects of the self. Klein developed the idea of pathological

splitting of “good” and “bad” objects through the defensive process of projection and introjection in relation to primitive anxiety and the death instinct (based on biology). Object relations derives its therapeutic power by showing how unconscious fantasies/motivations can reflect the way a person can distort reality by projecting and identifying with bad objects.

Paranoid Schizoid Position

The paranoid schizoid position is a fragmented position in which thoughts and feelings are split off and projected because the psyche cannot tolerate feelings of pain, emptiness, loneliness, rejection, humiliation, or ambiguity. Klein viewed this position as the earliest phase of development, part-object functioning, and the beginning of the primitive, undeveloped

superego. If the child views mother as a "good breast," the child will maintain good, warm, and hopeful feelings about his or her environment. If, on the other hand, the infant experiences mother as a "bad breast," the child is more likely to experience the environment as bad, attacking, and persecutory. Klein, more than any of her followers, understood the primary importance of the need for mother and the breast.

Part Objects

The first relational unit is the feeding experience with the mother and the infant's relation to the breast. Klein believed the breast is the child's first possession. But because it is so desired it also becomes the source of the infant's envy, greed, and hatred and is therefore susceptible to the infant's fantasized attacks. The infant

internalizes the mother as good or bad or, to be more specific, as a "part object" (a "good breast" or "bad breast"). As the breast is felt to contain a great part of the infant's death instinct (persecutory anxiety), it simultaneously establishes libidinal forces, giving way to the baby's first ambivalence. One part of the mother is loved and idealized, while the other is destroyed by the infant's oral, anal, sadistic, or aggressive impulses. In clinical terms Klein referred to this as pathological splitting. Here a parent is seen as a function of what the parent can provide, e.g., in infancy the breast, in later life money, material objects, etc. *I only love women who have big breasts!*

Persecutory Anxiety

The part of the psyche that threatens and terrifies the patient. It relates to what Klein has referred to as the primitive superego, an undifferentiated state that continually warns the patient of imminent danger (often unfounded). Paranoid anxiety is a feature associated with the death instinct and is more persecutory in nature. That implies the kind of anxiety from the primitive superego that is more explosive and volatile than from the more developed superego.

Projective Identification

This is a process whereby one splits off an unwanted aspect of the self and projects it onto the object, which identifies or over-identifies with that which is being projected. In other words, the self experiences the unconscious

defensive mechanism and translocates itself into the other. Under the influence of projective identification, one becomes vulnerable to the coercion, manipulation, or control of the person doing the projecting.

Psychohistory

Psychohistory does for the group what psychoanalysis does for the individual. It offers a broader perspective from which to view cross-cultural differences. Using psychoanalytic tools and concepts, psychohistory allows a better understanding of individuals, nations, governments, and political events—very much as a therapist analyzes the couple as a symbolic representation of a political group or nation (deMause 2002a, 2002b, 2006).

Reparation

The desire for the ego to restore an injured love object by coming to terms with one's own guilt and ambivalence. The process of reparation begins in the depressive position and starts when one develops the capacity to mourn, and to tolerate and contain the feelings of loss and guilt.

Reverse Superego

Whereas the healthy superego is a moral structure that goes through life distinguishing between right and wrong and good and evil, the reverse superego does the opposite. It is a concept I devised when writing an article for *Inspire* on "The Twisted Mind and Its Reverse Superego" (Kobrin and Lachkar, 2011) to describe what happens when one is praised for

being bad and punished for being good. An example of this would be countries that encourage mistreatment of women. At the domestic level it might sound something like: *He is so envious of me and my accomplishments. Instead of celebrating my success, my promotion, my awards, he goes out with the guys, making me feel like a nothing."*

Schizoid Personality

The central features of schizoid personalities are their defenses of attachment, aloofness, and indifference to others. The schizoid, although difficult to treat, is usually motivated, unlike the passive-aggressive. However, because of ongoing detachment and aloofness, the schizoid personality lacks the capacity to achieve social and sexual gratification. A close relationship

invites the danger of being overwhelmed or suffocated, for it may be envisioned as relinquishing independence. The schizoid differs from the obsessive-compulsive personality in that the obsessive-compulsive feels great discomfort with emotions, whereas the schizoid is lacking in the capacity to feel the emotion but at least recognizes the need. Schizoids differ from the narcissist in that they are self-sufficient and self-contained. They do not experience or suffer the same feelings of loss that borderlines and narcissists do. *Who, me? I don't care, I have my work, my computer, etc.!*

Self Objects

This is a term devised by Heinz Kohut. A forerunner of self-psychology, the term refers to an interpersonal process whereby the analyst

provides basic functions for the patient. These functions are used to make up for failures in the past by caretakers who were lacking in mirroring, empathic attunement, and had faulty responses with their children. Kohut reminds us that psychological disturbances are caused by failures from idealized objects, and for the rest of their lives patients may need self objects that provide good mirroring responses.

Self Psychology

Heinz Kohut revolutionized analytic thinking when he introduced a new psychology of the self that stresses the patient's subjective experience. Unlike with object relations, the patient's "reality" is not considered a distortion or a projection but rather the patient's truth. It is the patient's experience that is considered of utmost

importance. Self-psychology, with its emphasis on the empathic mode, implies that the narcissistic personality is more susceptible to classical interpretations. Recognition of splitting and projection is virtually non-existent among self-psychologists.

Shame

Shame is a matter between the person and his group or society, while guilt is primarily a matter between a person and his conscious. Shame is the defense against the humiliation of having needs that are felt to be dangerous and persecutory. Shame is associated with anticipatory anxiety and annihilation fantasies. *If I tell my boyfriend what I really need, he will abandon me*!

Single and Dual Projective Identification in Conjoint Treatment

In single projective identification, one takes in the other person's projections by identifying with that which is being projected. Dual projective identification is a term I originated in which both partners take in the projections of the other and identify or over-identify with that which is being projected (the splitting of the ego). Thus, one may project guilt while the other projects shame. *You should be ashamed of yourself for being so needy! When you're so needy, I feel guilty!*

Splitting

Splitting occurs when a person cannot keep two contradictory thoughts or feelings in mind at the

same time and, therefore, keeps the conflicting feelings apart, focusing on just one of them.

Superego

The literature refers to different kinds of superegos. Freud's superego concerns itself with moral judgment, what people think. It depicts an introjected whole figure, a parental voice or image that operates from a point of view of morality, telling the child how to follow the rules and what happens if they don't. It is often the "dos, don'ts, oughts, and shoulds," and represents the child's compliance and conformity with strong parental figures. Freud's superego is the internalized image that continues to live inside the child, controlling or punishing. Klein's superego centers on the shame and humiliation of having needs, thoughts, and

feelings that are felt to be more persecutory and hostile in nature and invade the psyche as an unmentalized experience.

Transference

Transference is a process whereby the patient transfers an emotion, feeling, or a past relationship object bond to the therapist, re-creating it within the therapeutic process. It is often an unconscious mechanism that can thwart or distort the patient's ability to see the therapist realistically. “You are using me and taking advantage of me just like my father.” Transference differs from projection in that this is where the patient cannot tolerate some part of the self and projects onto the therapist. *I don’t like being used; now I make you into a user.*

V-spot

The V-Spot is a term I devised to describe the most sensitive area of emotional vulnerability that gets aroused when one's partner hits an emotional raw spot in the other. It is the emotional counterpart to the physical G-spot. The V-spot is the heart of our most fragile area of emotional sensitivity, known in the literature as the archaic injury, a product of early trauma that one holds onto. With arousal of the V-spot comes the loss of sense and sensibility; everything shakes and shifts like an earthquake (memory, perception, judgment, reality). The V-spot is a way of meticulously pinpointing the precise affective experience.

Whole Objects

The beginning of the depressive position is marked by the infant's awareness of his mother as a "whole object." As the infant matures and as verbal expression increases, he achieves more cognitive ability and acquires the capacity to love her as a separate person with separate needs, feelings, and desires. In the depressive position, guilt and jealousy become the replacement for shame and envy. Ambivalence and guilt are experienced and tolerated in relation to whole objects. One no longer seeks to destroy the objects or the oedipal rival (father and siblings, those who take mother away), but can begin to live amicably with them.

Withdrawal vs. Detachment

Detachment should not be confused with withdrawal. Withdrawal is actually a healthier state because it maintains a certain libidinal attachment to the object. When one detaches, one splits off and goes into a state of despondency. Children who are left alone, ignored, or neglected for long periods of time enter into a phase of despair (Bowlby, 1969). The child's active protest for the missing or absent mother gradually diminishes and the child no longer makes demands. When this occurs, the infant goes into detachment mode or pathological mourning. Apathy, lethargy, and listlessness become the replacement for feelings (anger, rage, betrayal, abandonment).

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