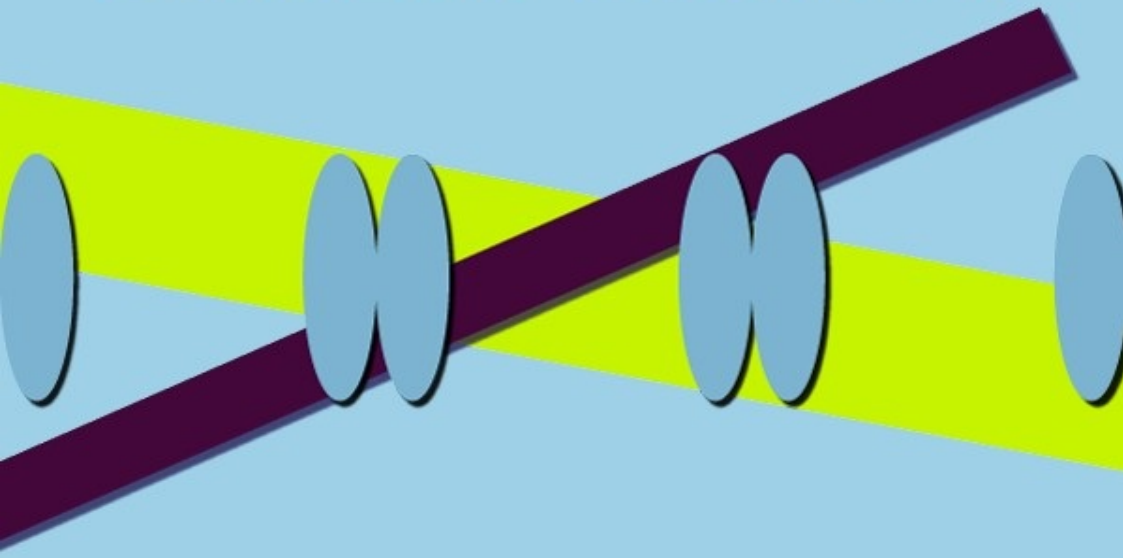
COMMENTS ON CURRENT THEORIES



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The dynamics and treatment of the borderline patient have been examined extensively by Otto Kernberg, James F. Masterson, and Richard D. Chessick as well as the present author. In this chapter their theories will be the focus of the discussion. In addition, we shall consider Heinz Kohut, for although he writes primarily about narcissistic disorders, he assumes that his theory concerning narcissistic personalities and some of his ideas regarding schizophrenia cover the main facets of the borderline syndrome. Other researchers who have contributed to the literature of the borderline or whose research is pertinent will be included where their writings are relevant to the theory being reviewed.

While there are broad areas of agreement among Kohut, Kernberg, Masterson, and Chessick, there are also, as might be expected, wide differences in their interpretation of the same phenomena. To complicate matters, in some of their writings the technical vernacular at times is difficult to decode. Therefore, when the chief concepts of these writers are presented, the original phraseology is retained to a great extent, but terms that might be regarded as cryptic will be clarified.

Each of these authors utilizes a developmental theory to explain the dynamics of the borderline patient in accordance with the presently accepted psychoanalytic version of development. Therefore, we shall start our review of these theories and treatment techniques by examining the concepts of "self-object" and "splitting," two popular ideas of primary importance in the thinking of Kernberg and Kohut based on Freud's, Melanie Klein's, Mahler's, and Erikson's postulations. While each author may have differences in approach, the main tenet is that the pathology of the ego, which begins in the first year of life, is a basic problem in the development of the borderline syndrome. The thrust of Kohut's theory of early onset is that the mother's personality is the main cause of the problem of the infant who will become the borderline patient. Kernberg puts more emphasis on constitutional factors, which are basic in his theory.

The "Splitting" Phenomenon and the Self-object"

Kohut originally wrote about "the ego" (1959), but modified this at an early period (1963) by alleging that he analyzes the "self" in line with Hartmann's theory of the subdivisions of the ego (the "self," the "self-representation," and so on), a concept related to narcissism. *Following a developmental motif*, Kohut (1975) believes that the analyst must function as a mothering person so as to help the patient make up the developmental deficits in the "self", a support that the depressive or withdrawn real mother

could not provide. The "self-object" is the focus of treatment. Self-objects are objects that are not experienced as "separate and independent from the self," an idea deriving from Freud's "anaclitic state." In my 1952 paper I expressed similar ideas, but I have changed my concepts since then.

Kernberg, too, proposes a "self-object" concept (using some of Hartmann's ideas) in an "object relations theory" modeled after Melanie Klein, with some modifications (1975, pp. 26-27). He says that the patient has *developmental defects present in the defensive system.* There is an interference with the patient's synthesizing capacity characterized by an early division of the ego into "good and bad objects" i.e., aggressive "self-" and "object" images. This division is due to a constitutional defect, genetically determined, expressing itself in an excessive amount of oral aggression that has to be defended against by projective identification, the main feature of which is "splitting," i.e., dissociation. Kernberg (1975, p. 25) considers the "splitting phenomenon" a distinctive mechanism in borderline cases (others find this mechanism in other types of cases). Splitting is connected with a "compartmentalization of contradictory ego states." A patient, Kernberg says, may at one moment manifest outlandish sexual or hostile impulses while at another time may swing to an opposite stance, conveying highly moralistic, virtuous, and compassionate sentiments, acting as if he never had engaged in the original impulsive behavior at all. The patient may project his own impulse-laden motives onto the therapist in transference or onto other

substitute objects. This is the patient's way of preserving his equilibrium.

Kernberg (1966) illustrated this phenomenon by citing a borderline male patient in his late 30s with a paranoid character structure who, in the third interview, vociferously accused Kernberg of rejecting him by passing him by on the street. The patient felt that he was being held in contempt by his analyst. Kernberg considered this a manifestation of a beginning need for a dependency in the relationship with the analyst. On subsequent occasions the patient voiced gratefulness and intense positive feelings toward Kernberg, but a few weeks later he shifted back to angry outbursts. During the period that he manifested gratefulness, Kernberg considered these feelings to be sentiments of "closeness and longing." (I would think of this as an appeasing masochistic attitude in transference.) When the patient was feeling good toward the analyst, he seemed oblivious to the fact that he had evidenced anger, in spite of remembering that he had possessed feelings of such an opposite nature. "It was as if there were two selves, equally strong, completely separated from each other in their emotions although not in his memory, alternating in his conscious experience." Kernberg could not discern this pattern in the patient's activities at work, his behavior there being socially appropriate.[10] Whenever Kernberg attempted to question either state of unrealistic emotion in its presence, the patient would elicit anxiety. This, Kernberg felt, pointed to the fact that the "splitting of the ego" was "not only a defect in the ego but also an active, very powerful defensive operation."

Kernberg postulates that certain mechanisms of defense operate differently in the borderline than in other patients, particularly the mechanisms of *isolation* and *denial* (Kernberg, 1967, pp. 669-671; see also Wolberg, 1973, pp. 130-131).

Kernberg (1967) believes that the borderline patient has a "constitutional defect" that prevents the normal mode of integration of perceptions. He accounts for this in the following way: Object relationships involve drive derivatives, affects, emotions, wishes, fears, images, and fantasies. Introjections are the "earliest point of convergency of object relationships and instinctual drive representatives" and "may be visualized as an essential 'switch,' bringing the ego into operational readiness." Splitting is the normal defensive operation in this early stage of development. There is an undifferentiated phase of development (Hartmann, 1939, 19501, a common matrix to the ego and the id (Freud's concept); and there is a specific stage in which the ego may be considered for the first time as an integrated structure, i.e., the 3-month period (Spitz, 1951).

Another defect in the borderline, according to Kernberg, is "a constitutionally determined lack of anxiety tolerance." This interferes with "the phase of synthesis of introjections of opposite balance," i.e., the phase from birth up to 8 or 10 months. The "quantitative predominance of negative introjections'' stems from "both a constitutionally determined intensity of

aggressive drive derivatives and from severe early frustrations." Kernberg says that in the borderline patient a constitutional defect interferes with the normal mode of integration of perceptions. This perpetuates the "splitting" that normally occurs in every child, due simply to the inability of the child in the first few months of life (before the id/ego differentiation takes place) to integrate the contents of his mind. The consequence is that, as a child, the future borderline never does give up the splitting, and it. in turn, creates a problem in the development of the autonomous ego functions. Kernberg attributes the *destructive mental images* in splitting to derivatives of the instinct that have not been handled owing to the constitutional defect. II would conceive of the aggression as stemming from a family situation where the parents are unusually frustrating.) Kernberg calls the aggressive images nonmetabolized ego states or introjects.

Freud thought of these fantasies as id representatives. Kernberg's idea is reminiscent of Breuer, too, who spoke of "hypnoid states" and felt these to be due to a constitutional inability of the individual to hold together the contents of his mind. In my view, Kernberg is describing a sadomasochistic defense when he speaks of these opposite "ego states."

The constitutional defects and the early frustrations create painful types of object relations. As a consequence, "all-out negative valence" increases anxiety and produces the need *to project aggression*, *which is taken back in the*

form of negative introjections, which then become "bad internal objects." But the need to preserve "good internal objects" leads not only to excessive splitting, but also to a dangerous "predepressive idealization"; in other words, the external objects are seen as totally good in order to make sure they cannot be contaminated, spoiled, or destroyed by the projected, bad external objects. When idealization of the parents occurs, it creates unrealistic all-good and powerful object images and, later on, a corresponding hypercathected, blown-up omnipotent ego-ideal, which is quite typical of borderline patients.[11]

Kohut has a different concept of the idealization of the parents, based on the child's "normal" need to be "merged" with an omnipotent person who provides him with a feeling of worth and self-esteem. Meyers (1978, p. 135) says that this corresponds "in development" to a situation where "little Johnny might fall hurting his knee and crying." His father, "whom he admires," would pick him up and then Johnny would feel "calm and secure in his powerful arms, as if he and father are one" (Mahler's symbiotic period and Freud's anaclitic state in the age of id/ego undifferentiation).

The question of the origin of the "splitting tendency." the predisposition of the ego toward it, and how other defensive mechanisms such as repression. introjection, and identification are related to it, encouraged Kernberg to formulate a tentative model which fused theoretical concepts from classical

psychoanalysis. Kleinian psychoanalysis, and the schools of ego psychology: Hartmann (1939, 1950), Jacobson (1954), Erikson (1946, 1950), Klein (1946), Fairbairn (1954), Segal (1950, 1956).

Kernberg contends that interpretation is a futile way of stopping the contradictions of the patient's behavior. Since splitting is not dependent on repression, efforts to deal with the pathology by delving into repressed, unconscious material yield barren results. To avoid anxiety, the individual will try to maintain the barrier between contradictory states. For this reason an active attack on the mechanism of splitting as a defensive operation must be made. This will stir up anxiety and help mobilize new defensive operations. In this way intrapsychic change may be brought about. *Repeated interpretations of the defensive dissociation which exists between contradictory states, or between lack of impulse control in a specific area and the patient's usual behavior, may mobilize the conflict in transference.* When regular psychoanalysis is attempted, says Kernberg, reality testing becomes defective and what eventuates is a transference psychosis (loss of reality testing and appearance of delusional material within the transference rather than transference neurosis). This indicates that there is a tendency to act out "instinctual conflicts" within the transference as a way of gratifying pathological needs. Yet efforts to treat borderline patients by supportive approaches merely serve to reinforce defenses and leave the patient where he was before. In spite of the effort to avoid transference emergence, negative

transference is prone to erupt in an insidious way: it is split up by acting out, both outside of treatment and, with emotional shallowness, within the therapeutic situation.

Kernberg (1968, pp. 601-602) outlines seven procedures in a "modified approach": (1) Systematic elaboration of the manifest and latent transference (without relating it extensively to early genetic origins) inside the therapeutic situation while elaborating the negative transference as it occurs in the patient's relationships with others. (2) Confronting and interpreting pathological defensive tactics that foster the negative transference. (3) Structuring the therapeutic situation (such as the setting of limits to nonverbal aggression) to block the acting out of negative transference. (4) Utilization of environmental resources, such as a hospital or day hospital for these patients whose acting out outside of therapy is too disturbing or so gratifying as to prevent progress. (5) Focusing on defensive operations that weaken the ego (splitting, projective identification, denial, primitive idealization, omnipotence, reduced reality testing). (6) Fostering those positive transference manifestations which help the therapeutic alliance with only careful partial confrontation of the patient with such manifestations. (7) Encouraging a more appropriate and mature expression of sexuality where necessary, to free it from its entanglement with pregenital aggression. These techniques, Kernberg feels, fall under the rubric of psychoanalytically oriented psychotherapy rather than formal psychoanalysis.

The borderline patient, according to Kernberg, uses “splitting” because of an inability to handle ambivalent feelings. He has not developed repressions because these are related to *conflict* and an ability to regard the “object” as *separate.* The borderline has a consciousness of “good” and “bad” but not at the same time. That is, he experiences relationships in terms of “black and white,” so to say, blotting out the one when the other is in the foreground. This is different from *denial* where there is *no consciousness in the disavowal.*

It is my impression that in all of the defenses mentioned by Kernberg —*dissociation, denial, disavowal,* and *repression*—there is, indeed, a rejection of mental content *due to a linkage* not with just one vague memory or the dim memories of a few experiences from 4 to 10 months but *with many memories of relations with parents over time that created conflict.* There is an accumulative effect over a period of years that necessitates defenses against the understanding of the conflict. It is a matter of the intensity of the conflict over what has been called “cumulative traumas" as to whether such mechanisms as denial and dissociation are used. As a matter of fact, denial is a necessity in a dissociative process, and *there is no denial and no dissociation without repressions.* The resolution of the conflict comes about through the organization of fantasies, the development of symptoms and acting out, (i.e., a return of the repressed), and the consolidation of a passive-aggressive, sadomasochistic personality brought about by relations with parents. Acting

out is a function of the patient's identification with parental figures, denied and projected.

Aside from the fact that there may be no such thing as dissociation in the early stages of infancy, we must have a more precise usage of the term. We should reserve the term *dissociation* to refer to the kind of defenses evident in the amnesias, the fetishes, and the various forms of multiple personality. Dissociation is fleeting in depersonalization and derealization and more lasting in the amnesias than in fugue states. But all of these defenses are based on *conflict* derived from relations with parental figures and *the attempt to avoid the anxiety in the conflict aroused by thoughts and feelings stimulated by current events.* The current events set off anxiety when the individuals in the interpersonal relations behave in a manner that is in any way reminiscent of the parents. The borderline patient projects onto these individuals the parental characteristics with which he is identified. Kernberg resolved the matter of defenses and their relation to identification and acting out by simply contending that the borderline patient has no identification system and therefore has no feelings of "real love" or "regard" for others and no true superego values, especially *guilt.* The borderline's acting out is the acting of "raw instinctual aggression."

Kernberg believes that the "ego defect" of the borderline is in the defensive system, and from the point of view of development the patient has

not passed through the separation/individuation phase (Mahler's elaboration and modification of ideas suggested originally by Freud, Rank, and others). The patient remains with the primitive "splitting" defense. The defenses are against his "primitive rage" and the expression of "raw aggression," which Kernberg sees as the source of the patient's acting-out tendencies rather than that the acting out is due to identifications with parental figures over which there is conflict. Kernberg is of the opinion that the borderline patient has not reached the stage of development where identification can form, the so-called period of "object constancy" beginning about 16 months. The borderline is "fixated" in the 4- to 12-month period.

The theory regarding "splitting" as a defense preceding repression, developmentally speaking, has been criticized by many psychoanalysts and psychiatrists as not being demonstrable (Gunderson, 1975; Gunderson, Carpenter, *&* Strauss, 1975; Gunderson *&* Singer, 1975; Heimann, 1966; Mack, 1975; Pruyser, 1975; Robbins, 1976; Wolberg, A., 1973, 1977). In my opinion identification is an important factor in all neuroses and in all psychoses; therefore, we cannot use Freud's or Mahler's preoedipal system as a guide (Wolberg, A., 1973, pp. 11, 135, 137-138).

Kohut (1971), too, uses the concept of splitting prior to repression, proposing a "vertical split" in the ego by "disavowal" (Freud's phrase). For Kohut, however, the "split" (the dissociation) results from a developmental

phenomenon related to the "self." There is an early period when the "grandiose-exhibitionistic self" is operative. The future borderline is unsatisfied at this stage by the deficient mother so that part of the "self" becomes fixated, denied (disavowed), and converted into fantasy. Bifurcation, as Freud called it, takes place when in the case of neurosis part of the libido is split off to become fantasy. Modern theorists apply this principle of Freud to ego formation as well as to the instinct, and the effects are seen in the form of derivates. In the "vertical split" there is a *consciousness* of the "grandiose self," while at the same time the individual is aware that he is not an important or "grand" person. In *disavowal* both aspects of the ego are conscious, but one part is *unaware* or *ignores or disregards* the other. Kohut uses a concept similar to that of Kernberg but in relation to the development of the *"self"* aspect of the ego rather than to the *defensive* side of the ego. Chessick (1977, p. 56) says that there is disagreement as to whether *disavowal* ought to be called a splitting of the ego or a splitting of the "self" in the service of defense. In any case, "splitting" presumably happens before the "repressive barrier" is formed. This theory derives from Freud's ideas of schizophrenia, applying data to concepts of narcissism and regression.

Freud theorized that the schizophrenic patient did have identifications, resolved and integrated in the ego, but that in the process of "regression," which was a symptom in schizophrenia, the ego was broken up due to "splitting." It was a kind of disintegrating of the ego into parts so that what

was present was the "abandoned identifications," which were then remade or distorted. It could be considered a "going-back-in-time" concept, or an undoing of an integration, throwing the "introjects" into a fantasy—or more precisely a delusion—as a disavowal of and a remaking of reality. Actually, it seems to me, *the delusion is a form of integration*, a fantasy that takes on a more rigid and permanent type of organization while disguising the root of the acting out by projecting certain memories of the original figures (the parents). These memories have to do with the identifications in the form of defensive fantasies, for example, voices and ideas that require a particular kind of action. These are defensive maneuvers to exculpate the parents as the "batterers," or the "persecutors," or the "manipulators." The borderline, however, does not become motivated in his behavior by an organized delusion; rather he has fleeting paranoid ideas and a loosely defined delusional system that is activated in times of intense stress.

Narcissism and Its Relation to Self-objects

Kohut postulates a stage of narcissism in which a "normal primitive self" has a "separate line of development" from that of sexual development. In the ordinary course of events an "idealized parental image," which is a "selfobject," is formed as an aspect of development (a precursor of identification and the superego). According to Chessick (1977, p. 64), Kohut considers this "image" to be in the nature of a "transitional object." Therefore,

it is a residual of the period before the id/ego differentiation takes place, antedating the period of "object constancy." Kohut refers to narcissism as developing "side by side with object love." The analyst is a "self-object" in the patient's eyes, and a self-object is a need-fulfilling object, as Meyers (1978) says, "not experienced as a separate independent being having its own needs" etc. but "experienced as part of one's self, like one's arm." The "self" has two parts: the *grandiose self* and the *idealized parental image* and both evolve from a stage of primary narcissism. Goldberg (1978) has explained that one can expect maturation of the self to progress along one line and sexuality along another "rather than conceiving of narcissism as developing into object love."

Clark (1919) used Freud's concept of the infant emerging into a state of secondary narcissism, getting into this state by being able to "identify" with the object and thus having feelings of empathy for the object. Kernberg (1976, pp. 57, 63, 64) uses a similar idea. The mother is a self-object to the infant, according to Kernberg. The mother is also "one" with the child according to Mahler et al (1959). Spitz (1965) thought that there is an absence of an "inner organizer" in the child's mind in the first three months so that the adult has to serve as a buffer, and this is why the mother and child are "one." It is only when "object constancy" is achieved that separateness can be discerned by the child (from 16 to 24 months). This theory, as we shall discuss later, should be discarded in the light of modern infant research.

There has been a tendency to equate “object constancy” with the ability to hold the object in memory when the object is not present. Kohut uses an idea similar to Schaffer’s (1958) in relation to object constancy. He contends *it is pan of the process of internalization.* This process begins, according to Kohut (1977, p. 86), when the infant or child is “anxious” and the mother comes to comfort him: he feels the mother’s touch, hears her voice, and the like “as if this were his own.” The following is the order in which the event is experienced: there is mounting anxiety within the self— the signal: the self-object (the mother) performs; this is followed by calmness and absence of anxiety. The “psychological disintegration products that the child had begun to feel when his anxiety increased disappears when the self-objects” (i.e., the mother) performs. Stabilization then begins to take over and the “rudimentary self is reestablished.” These are need-satisfying activities performed by the mother, the self-object. The event is and “empathic merger” of the self and the self-object.

Kohut feels that interpretation in psychoanalysis follows a similar pattern —it is a means of relieving anxiety by explanation in the context of empathy. *The analysis is a way of examining “self-development” and “self-experience" in relation to “intrapsychic development.”* The analyst joins the patient in self-experiencing; i.e., he becomes the mother rather than remaining neutral as Freud suggested. The mother and child are “fused” in the infant’s mind, as in Mahler’s symbiotic phase or Freud’s anaclitic

relationship. As the infant experiences the failures of the mother to respond as he would like (i.e., to fulfill his every need and wish), he gradually "internalizes" the functions that the "self-object," the mother, has performed. This is called "transmutting internalization" by Kohut rather than introjection or identification. Kohut believes that "ego structure" is built up in this way. He postulates a developmental line for narcissism through an "ego ideal" that is the "internalization" of the "idealized self-object," and this provides the basis for the formation of a "cohesive self." The preoedipal phase is then followed by an oedipal period. In this period further structure is acquired to form the ego and superego, the ego ideal being absorbed, so to speak, in the superego. The borderline patient due to his genetic defects and his experience with an inadequate mother does not develop this "cohesive self"; consequently, he does not go on to the object constancy stage.

When the self-object has not performed properly in the child's infancy and the child has been deprived of "merging experience," he will not be able to build psychological structures capable of dealing with anxiety in an adequate way. In the normal course of developmental events the infant gradually takes over the functions of the self-object. Where this is not possible, the child has a lack of normal tension-regulating structures la weakness in the ability to tame affects), and this results in an inability to curb anxiety. The acquisition of faulty structure then leads to the propensity toward active intensification of affect and the development of states of panic.

Object Constancy, Narcissism, and Early Development

The period of *object constancy* makes its appearance at different times according to different authors. Between 16 and 18 months of age the child has a “sustained mental representation of the mother” so that the child uses his memory and his fantasies to soothe himself, having “internalized" the soothing behavior of the mother. Prior to this he may use an object, i.e., a blanket or a toy animal for this purpose. The theory is, however, that “libidinal object constancy” requires another year.

Some modern theorists, in contrast with classical theorists, say that memory is established by 3 months (Caplan, 1973, pp. 82, 85-87). De Casper (1979, p. 227) seems to have done experiments to indicate that *learning and memory are present at birth.* Object constancy is supposed to be established when the infant can “remember” the object when the object is out of sight. This does not happen, according to psychoanalytic postulations until 16 to 18 months. The theory is that the age at which the child will take “anyone as mother” extends to about 7 months; thus it is up to this point that the mother and child can be considered in Mahler’s terms as “an omnipotent symbiotic unity” (Mahler et al, 1959, p. 822). This means that the child does not distinguish between himself and objects so far as his “need-satisfying requirements are concerned.” This idea, however, does not conform to recent experiments in development (see Caplan, 1973, pp. 85-91). Mahler says that

object constancy is not complete until the beginning of the third year. She describes a crisis in the infant's life associated with the "rapproachment phase" as the child begins to internalize certain events (Mahler et al, 1959). This idea of "crisis" follows Freud's concepts in that he proposed that walking makes the "omnipotent infant" acutely aware of his helplessness and as a consequence he develops "separation anxiety." The mother is then seen as powerful, and the infant feels weak. Mahler states that as the child begins to realize the separateness of himself and the mother, his omnipotence is reduced. Too sudden deflation of this sense of omnipotence and control, however, tends to evoke the grandiose view of the self and idealization of the omnipotent parent. This, according to Mahler, is similar to the *narcissistic defense* described by Kohut (1971). As I understand it, Kohut does not see the "grandiose self" as a defense but as a normal developmental phenomenon. It is Kemberg who thinks of the grandiose self as a defense. If thwarted, this grandiose self remains, says Kohut, and becomes a defect of the "self," due to the deficiencies of the mother and the lack of "transmutting internalizations."

Settlage (1977) contends that we must understand the difference between *object permanence* (Piaget) and *object constancy,* a psychoanalytic concept. In addition to *cognitive representation,* which is inherent in object permanence, object constancy includes the intrapsychic representation of the human love object in "libidinal" and "affective" terms. Caplan (1973, pp. 83-92) reports that the child relates in an "affective" way at 2 and 3 months. At 3

months the baby is beginning to have an image of different people and of himself. Most theorist presume that “absence of the object” and then “presence of the object” or “anger toward the object” and then “good feelings toward the object” mean in intrapsychic terms that the “images of the object” are loving and disapproving, are “good” and “bad,” “loved” and “hated.” The opposites begin to be registered. Current research tells us that the infant in the first month is able to react to stimuli of both people and objects, but he shows preferences for people over things when people are present (Caplan, 1973, pp. 53-55).

Kohut (1971) writes that normally the “idealized parental image,” which is at first undifferentiated from the self, is finally integrated through identification, and separation takes place as the infant begins to experience approval from the mother. At this point “object constancy” has been achieved (12 to 18 months). “Integrated images” are essential, says Kohut, in the formation of object constancy, which is a precursor of the ego ideal and the superego. In the period of object constancy, not only can the child tolerate some separation from the mother, but he can also experience good feelings for the mother, not clinging to her simply as a “need-satisfying object.”

The self-object, according to Kohut, is different from how Kernberg (1975) conceives of it; it is the source of the later pleasure we feel when we “obey the dictates of our conscience.” This stimulates our need to “live up to

our own ideals." Originally, the self-object, as the "grandiose self," is a precursor to the infant's desire to please the parents and to gain approval for them, a forerunner of the capacity to identify. According to Kernberg, the ability to achieve object constancy comes from the infant being able to overcome his aggression through the defense of projective identification and thus to develop some good feelings toward the object. The aggression is tamed through the process of projective identification as delineated by Melanie Klein, and object constancy is finally achieved, during which the infant can begin to identify with the object. The first step is the development of empathic feelings; the second step is an appreciation of what the object does for the infant. Kohut feels that the infant gains self-worth by receiving praise from the mother. He loses self-worth if the mother is depressive and ungiving or disapproving.

Masterson (1972) embraces certain aspects of the theories of Kernberg and Kohut and has a notion based on some of Fairbairn's ideas that he schematizes in relation to the individual's response to an "exciting object," which is also a self-object. He comments on the patient's *fear of abandonment* as a factor in the building of defenses. He believes that true separation from the mother does not take place in the borderline patient. Chessick also emphasizes the patient's fear of abandonment, citing Odier (1956) who speaks of the patient's "neurosis of abandonment." Chessick mentions the patient's oscillations between love and hate, security and insecurity,

dependency and paranoia, this latter described by Leuba (1949) as fear of penetration, fear of deception and betrayal based on "overfeeding" and "pseudogiving" accompanied by a "hidden stream of demands." Chessick cites certain ideas of Modell (1963; 1975) regarding the persistence of primitive object relationships as the narcissistic defenses against the "illusion of self-sufficiency" as opposed to a sense of object love and security based on real experiences in a "holding environment" such as is envisioned by Winnicott (1965) to be necessary for the health development of the individual. Chessick also sees value in Winnicott's (1951) concept of the "transitional object phase," the stage of primary narcissism when there is "no object" and the anaclitic or "clinging" stage where the mother becomes the object. Chessick mentions the "intrusiveness of the mother" (Heinmann 1966; Mahler et al, 1975) as an important idea, and he considers that the patient has identifications "of at least some adaptive properties," with "some parental or grandparental figures," stating that sometimes the identifications do not occur until adolescence. He says that up and down the ego axis there are "inherited styles of defense and primary autonomous functions."

Kohut is of the opinion that the borderline is one form of schizophrenia and that the same types of transferences are manifest in the schizophrenias as in the narcissistic character, although schizophrenia is a separate syndrome and possesses tranferences of a different quality. Each represents a "fixation in narcissism" due to the inability of the mother to provide the

necessary emotional support for the child. As frustrations occur normally, the child tries to preserve his omnipotence by assigning it to the *grandiose self* and the *idealized parental image.* As the child gradually is able to perform some of the functions that the parent performed, he “internalizes these functions” and they become a part of the “idealization of the self.” The selfobjects are then given up, and a “structure” begins to form in the individual’s mind. There are “self-representations” in relation to the *id,* the *ego*, and later the *superego.* As structure forms, the agencies of the mind are solidified by the “repression barrier” that surrounds each. Expressions of the transference are based, first, on the “grandiose exhibitionistic image of self," a “self-object” which derives from relations with the mother and emerges in treatment as the “mirror transference” and. second, on the “idealized self,” also a self-object.

Kohut focuses on the developmental aspects of the “self" and targets his analysis on *self-esteem* in contrast to Kernberg. Kernberg tackles the *defensive operations on the ego,* with special attention being paid to “ego strength,” “structural characteristics,” and the “pathology of internalized object relationships.” He sees the patient's ego defects as (II an inability to perceive reality. (2) an inability to differentiate object from self, (3) an inability to integrate good and bad in a single person or in the self, and (4) an inability to repress aggression.

Kohut does not specify which "functions" of the ego are missing in the borderline, but he says that the way in which the self-object develops is a vital factor in the formation of the *self-system,* i.e., the manner in which the individual regards himself. *Poor self-esteem* is the main defect in the borderline ego evolving from the relations with a mother who cannot fulfill the role of a caretaking person. Patients lacking in appropriate self-esteem have been *unduly frustrated* by parents lacking in empathy, and they tend to have the following traits: (1) insufficient ego cohesiveness; (2) hypersensitivity; (3) feelings of emptiness; (4) poor tension regulation; (5) hyperexcitability; (6) lack of initiative; (7) problems with aggression; (8) perverse sexual patterns; and (9) search for an anchor. These traits are due to *fixation at the narcissistic stage* that causes the individual to have a tendency toward fragmentation of the self and a perpetuation of the grandiose self rather than a more mature development. *The analyst must create selfesteem* since this has a pivotal function in the emergence of the ego and the superego. Kernberg says that "introjections" are the earliest point of convergency of object relationship and instinctual drive representations and are the essential switches bringing the ego into operational readiness.

It is possible that when Kernberg speaks of "good" and "bad" introjects and of "pathological internalized object relations" in borderline patients, he may be describing in his terms what I refer to as the "identification system"—or, more precisely, the *identification fantasies,*—since I define identification as

a defense basic in all neuroses and in all psychoses. I would not use the term "introjection" as applied to the early stages of infant development, nor would I think of the early infant as being able to "identify." In descriptive terms "identification" implies a learned behavior pattern determined by the communications of the parents; in terms of neuroses and psychoses it means a *neurotic behavior pattern provoked by the parents in the service of their own defenses.* When the child adopts the identification pattern, he does so *in defense* so that the patterns, in fact, are an aspect of the child's defensive system. After the behavior becomes a chronic pattern, projective defenses are employed in order to deny the implications of the interlocking defensive family identification system. This process takes time, and the total defensive picture may not be complete before early adolescence. Then the behavior is often erroneously, I believe, considered to be part of the "oddities" that occur in adolescence.

In Melanie Klein's terms, projective identification is a "normal defense" of infancy that sets in motion the process whereby an instinct such as aggression is projected onto another person (the mother) and is then introjected as a "bad object." Later this projection spills over to the father. Since I consider learning to be a different process from what is presumed to be introjection and/or identification and since I do not embrace Klein's formulation, my idea of the dynamics of identification differs from those presumed in the current ideas of borderline pathology just discussed.

Identification, in my terms, is the adoption by the child of roles actively projected onto him by both parents; the roles and identifications that they represent are, of course, learned.

It is due to the patient's denial mechanisms that the concept of "splitting" has been introduced, but the concept of "splitting" as a characteristic of the defensive structure of the infant seems to be an esoteric concept. I conceive of splitting as dissociation and therefore an hysterical phenomenon. The infant does not develop hysterical mechanisms although he can "tune in" and "tune out" stimuli (Caplan, 1973, p. 28), and this capacity may be instinctual. This, like certain other characteristics, such as fear and the capacity to imitate, may belong to the self-preservation potentials of the individual, utilized as an element in the implementation of a defense. "Tuning in" and "tuning out" may be related to the "isolating technique," which has a neurophysiological base and which will be discussed later. These together may make it possible for hysterical defenses to be organized. A paper by Kagan (1979 b) is of interest here since it speaks of certain behaviors that "emerge" as part of the developmental process and are thus genetically evoked, while other behaviors are "psychologically" determined, i.e., are products of experience in this world. My thought is that whatever the genetic base of the self-preservative behavior, the content both emotional and cognitive is related to experience in this world; thus the psychological significance of the behavior is built out of experience and learning in the life

span of the individual.

The concept of “self-object” does not appear to be consonant with the dynamics of infant development as we know it to be today (Wolberg, A., 1977). The infant’s “mind” is an organized entity shortly after birth, perhaps before birth, and he not only relates to objects in a most meaningful way, but his behavior demonstrates that he has memory for the effects of his experimentation with the environment (Caplan, 1973).

The conceptual basis of the idea of a “self-object” so prominent in Kemberg’s and Kohut’s theories derives, first, from Freud’s idea of the “anaclitic” relationship and, second, from Melanie Klein’s object relations theory, which purports that the “instinct” becomes an “object” in view of the projection of the infant’s own aggression and an introjection of the aggression as an object. The instinct is “incorporated” or taken back into the infant’s psyche as an object—more precisely a “part object” (Segal, 1964), —by the "normal” process Klein described as projective identification. This is obviously a different approach than the one in my concept of the dynamics of projective identification. The idea that the infant has a symbiotic relationship with the mother (Mahler), or what Freud called the “anaclitic” or “clinging” relationship, implies that the mother and child are a closed system. This is not so in any family. A problem with the concept of “self-object” is that it is modeled after Freud’s idea of an “undifferentiated state” where the infant and

the exclusive mother are "one." The "undifferentiated state" does not take into consideration the infant's complex autonomous behavior that is present at birth and continues in more and more complicated form as the first year proceeds; nor does it take into account the infant's emotional relations with several others besides the mother in the family and what he learns from these contacts.

I believe that in the borderline we should look at what is being called "pathological internalized object relations" as a phenomenon that in reality is a nest of fantasies (the identification fantasies) sadomasochistic in nature that reflect the sadomasochistic relationships the borderline individual has had with the parents, *over time*, the fantasies disguising the traumatic aspects of the relationships in defense. Part of the conflict of the child is over the "good" and "bad" parts of the parents. It is difficult for the infant and young child to tolerate the "bad" parts because they are life threatening. The neurotic parent is "bad" out of anxiety and the need to maintain a neurotic equilibrium. His "badness" is a controlling mechanism and, in addition, constitutes a way of projecting his own hostile parts onto the child. The parent needs the child to act out a destructive role in order to deny his own destructive needs. Denial is a necessity for the parent. The child does not deny at first; instead he confronts as a self-preservative process. But he is made to feel guilty and is punished for this confrontation, and soon he sees that he too must deny. This conflict is threatening to him, and he is full of insecurity and anxiety.

The borderline patient projects his identifications because when he acts them out. they are destructive to him. His self-destructive tendencies are based on his identifications with the hostilities of the parents. This is what Freud used to refer to as the "punitive superego," but he interpreted this phenomenon as an internalization of the parents' attempts to control the aggressions of the child. In my view the aggressions do not appear automatically; they are evoked by the hostile and inhibiting behavior of the parents due to their neurotic anxieties. The parents use the child as a projective object, as a defense, or, in other words, as a means of expressing their own identifications with their own parents which they wish to deny (Wolberg, A., 1960). The punitive parents force the identifications on to the child. Through shame, and sometimes physical battering, and through sexual seduction (or what Freud might have called incestual impulses) the identifications are played out and finally adopted by the child. This is behavior that is *learned* rather than the adoption of defense to control bad instincts.

Freud (1923) spoke of "libidinal dangers" that create a reaction of the fear of being overwhelmed or annihilated. These would include the controlling behavior of the parents. Most authors do not consider the father in this early picture, as I do. According to my understanding of the dynamics of borderline patients and of projective identification, the father is intimately involved along with the mother as an integral part of the family's defensive

system, and the infant is a family member at birth, immersed in a group process with all members as well as with relatives and friends. The infant is a member of a social system, right at the start, and relates to many people and many things, and learning begins a few hours after birth (Wolberg, A., 1977).

Apparently Freud's pleasure-unpleasure principle has validity with respect to psychologically, more precisely, environmentally determined (learned) behavior, including identifications with people. We find that normal objects evoke "affects" of pleasure and unpleasure in the infant and that the neurophysiological apparatus receives these messages. Indeed "affect" is present from birth on (Caplan, 1973, pp. 54, 71). But "good" and "bad" as ethical concepts meaning "danger" become factors only when there is real danger from the parents' aggressions. The fear reaction, which is phylogenetically determined, appears between 8 and 12 months so that when actual danger is present, anxiety and tension are coupled with fear. How long does it take before fantasies are organized as part of the defense against danger? Perhaps these appear around the age of 2½ or 3 when the child begins to defend against the parents' controlling tendencies and punishments by projecting danger from shadows on the walls, and so forth. As he begins to conceive of "good" and "bad" stimulated by (1) the admonitions of the parents and (2) his own understanding of the reality situation, the superego thus begins to form and is "split," so to say, due to these two elements. The defenses of the parents help them to deny the reality, while the child sees the

reality. But the parents insist that the child deny too; so the child resorts to what Geleerd (1965) has called “denial in the service of the need to survive,” or what I believe to be the development of identification with the parent (the aggressor) and denial of the identification. The identification would be learned over time, but it is not a function of the learning process itself.

The child begins to defend in this situation by having fantasies that depict his problem of “giving in” to the pressure of the parents to distort reality. He develops sadomasochistic fantasies then, and we find phenomena such as Freud (1919) described in his essay “A Child Is Being Beaten.” These fantasies represent the child’s “internalizations” of the sadomasochistic experiences with parents and are based on the anxieties associated with the identifications that are beginning to form. They contain the meaning of the child’s conflict, which can be ascertained through associations as one would analyze a dream. We give the word “internalization,” therefore, a special meaning, distinguishing it as a special kind of learning associated with the process of identification to differentiate it from all other kinds of learning. It is related to defenses against anxiety and the neurotic resolution of conflict. Here we have an instance of the superego as influenced by the parents being “bad" while the id or the phylogenetic schedule aids the self-preservation aspects of the child's behavior. It seems that Kohut's list of symptoms or “traits,” while they are descriptive, do not apply across the board. The borderline patient may be “hypersensitive” (somewhat paranoid?), for

example, but not in every area; he may “lack initiative,” but he can be very successful in his work while being very unsuccessful at home or with friends. These traits operate in selective ways.

Kohut believes that while “narcissistic personalities” can tolerate the transference in treatment, borderlines, due to their particular defects, cannot. In the narcissistic personalities the two main transferences—(1) grandiose or mirror and (2) idealizing—can be worked through because of a certain “cohesiveness of the self,” but when these transferences occur in the borderlines, who because of their defects do not have this cohesive self, the threat of “ego shattering” or fragmentation makes the task of working through difficult, if not impossible. The lack of stability in the self is due both to genetic defects, which Kohut does not specify, and early untoward experiences with the mother.

With “narcissistic personalities,” as has been mentioned, the inappropriateness of the grandiose fantasy must not be mentioned, says Kohut; therefore, the transference reactions are met by supporting measures. In the grandiose transference “regression is set in motion” by the analytic situation, and the goal is to establish a “narcissistic equilibrium,” which the patient feels as “boundless power and knowledge” and as “aesthetic and moral perfection.” These attributes are more or less undifferentiated in the therapeutic regression, which leads to “very early fixation points.” Just as

there is a “cohesive therapeutic revival” of the “idealized self-object” (introject) in the “idealizing transference” in the narcissistic neuroses, “the grandiose self” is therapeutically reactivated in the “mirror transference.”

Kohut’s grandiose (mirror) transference, I believe, is an aspect of the sadomasochistic pattern (the sadistic side) and has no relation to ego deficits as linked to perception and learning. It does, however, have a definite function in the patient’s low self-esteem, his defensive system, i.e., his sadomasochistic interpersonal relations, particularly the masochistic aspects of the personality. If we must talk about an “ego,” then we might say that the patient has a sadomasochistic type of ego organization as revealed in his fantasies rather than that he has ego deficits. In a book edited by Goldberg (1978, pp. 227-245) there is a case that is a reminder to those who work with borderline patients that the patterns in acting out are not merely reflections of an early unpropitious environment. It is obvious in the report of this case that even while the patient was attending college, he had a very neurotic relationship with his parents that was sexually tinged. He reported back to them by letter his sexual exploits, writing to them practically every day. (This would be a form of sexual seduction on the part of the parents and an identification on the part of the patient with the parents' sexual perversions.)

In narcissistic personalities (and in borderlines) the “grandiose transference” takes three forms, according to Kohut: (1) the “archaic merger,”

(2) the less archaic "twinship," and (3) the still less archaic form, the "mirror transference." Kohut believes that grandiosity may be tinged with delusion and that some people, who have special gifts of intellect, in spite of their grandiosity, may succeed in life on the basis of these gifts. The average person who manifests grandiosity, however, may not be able to accomplish this. Kohut refers to Freud and Goethe as people with special gifts. In this context, he cites Eissler (1963) who commented on Freud's paper "A Childhood Recollection" (1917) and who also mentions Goethe's autobiography *Dichtung und Wahrheit.*

Kohut believes that as the analyst helps the patient acquire the missing elements in his ego, the aggression abates and the analysis of aggression becomes easier. The "mother is a "longed-for object," an object with whom the patient desires "fusion." During psychotherapy the object is not only longed for, but also is *needed* in order to develop the ego functions that were not established in childhood. Kohut is correct in assuming that if one works with the low self-esteem (the masochism) first, the aggression will reduce somewhat. The anger will still have to be analyzed and the revenge patterns with which the anger is finally associated attended, but this can be done at a later date. This tactic seems to be in line with the findings of Whitehorn and Betz (1960) and Betz (1962).

Kernberg (1975, p. 226) disagrees with Kohut regarding the origin of

the *grandiose self*, which Kernberg refers to as a "pathological self-structure," also a "self-object," and which he says is the same as Rosenfeld's (1965) "omnipotent mad self." Kohut regards the "mad self," or its equivalent, as a *fixation* of the "archaic normal primitive self." Kernberg, however, considers it a reflection of a *pathological structure*, clearly different from normal narcissism in early normal development; he views the "grandiose self" as *a structure that is defective and different from birth* in the borderline case (Kernberg, 1975, pp. 133-134).

Kohut's activation of the grandiose self to help the patient achieve full awareness of it, is, according to Kernberg, an "emphasis on libidinal conflicts with an almost total disregard of the vicissitudes of aggression." This, in Kernberg's opinion, interferes with a systematic interpretation of the defensive functions of the grandiose self.

Kernberg argues that initially the patient must be made aware of his need to devalue and depreciate the analyst as an independent object, which, as Melanie Klein insisted (1946, 1950), he does in order to protect himself from retaliation. According to Kernberg, the aggression is a "projected sadistic reaction" that stimulates fear of retaliation in the patient activated by "real or fantasized frustrations" from the object. Fear, because of the patient's attack on the analyst as a primitive "giving" or "ungiving object," is an important "mother transference" against which narcissistic resistance has

been erected. This transference needs to be explored and interpreted systematically, right at the beginning. Kernberg views the hatred of the mother as a projection of the infant's own excessive oral aggression, and this is extended to the father as well (Kernberg, 1975, p. 41). Thus the aggression is irrational, and genetically determined.

Aggression in my viewpoint, as already stated, is evoked in the child by the parents who are projecting their own aggression onto the child. The parents' aggressions, however, are defensive and are connected with identification fantasies. These fantasies are not only defenses in themselves, but are at the same time depictions in symbolized form of the identifications the parents had with their own parents, representing the *interpersonal relations,* sadomasochistic in nature, that produced the identifications. Projective identification, therefore, has to do with a son or daughter's denial of hated identifications with parental figures, parents who in reality through sadomasochistic interpersonal encounters, over time, demanded the identifications in the interests of their own neurotic defenses. In turn, when these sons or daughters become parents, they project their unwanted identifications onto their children and others with whom they are ordinarily related. There seems to be a consciousness on the part of the patient to act out sadistic impulses. My patient Mabel Claire, for example, had the idea that she might act with hostility if she had children, and she did. Another patient, Flora O'Toole Levy, had similar feelings, and she acted out over the years in

hostile ways with her sons. There is, in the evocation of projective identifications, three elements: (1) the parents use of each other as projective instruments, (2) the parents use of their children as projective objects enmeshing them in their defensive needs and (3) the parents use of "others" as projective objects. In the case of their own children, parents can control the situation through punishment and reward and eventually, over time, stimulate the kinds of roles they need. In the case of "others," they do not have this control. It is possible, of course, to find others who will engage in the sadomasochistic encounter, but usually this occurs only when the individual settles into an intimate relationship where the pattern can be used coordinately for neurotic purposes. Those who do not fit into these patterns do not have intimate relations with borderlines, but the borderline may project onto and act out his neurotic needs toward these "others" in any case.

The "ungiving projection" that Kernberg refers to in transference is, in his terms, a manifestation of oral aggression. This is an unrealistic picture of what the parents are like and thus is not a manifestation of identification. In my way of thinking, while not an exact duplicate of a real experience, this "ungiving projection" is a symbolized reproduction of the kind of relationship the child actually had with the parent. On occasion the patient may try to duplicate real experiences, as the patient who detailed his sexual exploits to his parents seems to have done (Goldberg, 1978, pp. 224-245). We may talk of this phenomenon as being a mother or a father transference or a fusion of

both since both parents at times were ungiving and hostile.

Grandiosity, in my opinion, is a defense, but it is a defense that is organized much later in life than in infancy; it is a defense that helps the patient submerge (repress) some of his feelings of self-contempt as well as his anger and revenge feelings. I agree with Chessick (1977, pp. 112, 115) that the sophistication attributed to the infant at ages 6 to 7 months is highly speculative. That the infant actually "envies," is full of "oral aggression," possessed of "fantasies of power and beauty," "grandiose and controlling," "filled with love and hate." and so forth are projections of adult ways onto an infant.

The popular ideas that the infant's mind has no organizing capacity and is unintegrated due to aggression appears also to be an error. The infant learns from birth; he has preferences; he sees patterns of objects as wholes; memory is firmly established; he communicates right from the start in various ways—eye contact, crying, withdrawal by falling asleep, gesturing, and smiling. Apparently in later papers Kernberg has had second thoughts about aggression saying that the infant "seeks love as power" but it is the adult who "seeks beauty" equating it with security.

According to Kohut (1971, pp. 56-66), the personality of the "mother" in the early phase of development is more important than gross environmental

events such as separation from the object by such contingencies as death or divorce. In normal development “firming and buttressing of the psychic apparatus,” especially in the areas of the establishment of “reliable ideals,” takes place during latency and puberty (8 to 12 years) with a decisive final step in late adolescence, i.e., during the period of “object loss.” “However crushing this may be,” the object loss will be tolerated by the firm ego, but where the mothering person has failed in her functioning, the resultant ego lacunae do not permit a “firming.” This is the case with the borderline patient.

Chessick (1977) has written an excellent summation of the various developmental systems presented by Mahler, Kohut, Kernberg, and others. These systems do have a relevance to understanding the borderline patient. but they do not reflect, in my opinion, what actually happens in infancy. All follow the modern practice of transferring some of Freud’s ideas of sexual development into nonsexual terms and relating them to the ego. This has not helped to clarify psychoanalytic theory. Freud's brilliance is not reflected in this concept of ego development. It is a fact, however, that they have repeated his errors in the face of overwhelming evidence that some of his speculations could not possibly be true. Freud did recognize an “innate schedule" in development, but his concept of what appears as a consequence of the genetic code, such as sadomasochism and aggression, does not always coincide with what modern theorists are advancing as aspects seen in infant and early behavior (Kagan, 1979 b). The “innate schedule” does unfold regardless of

what happens to the child as a result of environment, and there are thus appearances of certain behaviors at certain periods. Sadomasochism, however, does not seem to be one of those innate factors, and aggression will appear only after a great deal of frustration. *Sadomasochism seems to be a learned response after much conditioning in relations with neurotic parents.*

In psychoanalysis the assumption is that the theory of infantile sexuality is correct, and any proposition ritualistically must fit into this aspect of the libido concept (even when the theory does not make any sense); otherwise the individual who is practicing is not considered to be a psychoanalyst. This is a problem for many who treat borderline patients since the current idea among most analysts is that the borderline syndrome is a preoedipal problem, the "fixation period" occurring in the first year—or at the most the first year and a half. Within this framework there are many mystical ideas that have thrown psychoanalysis off balance in its efforts to be scientific. The grandiosity of the infant is one such idea, and the theory of primary and secondary narcissism with their accompanying primary fantasies is another divergent side step. In actual fact the infant is very busy learning and can be said to be preoccupied in the first few months after birth with getting movements organized in a way that will make it possible to cope with the environment. As a means toward this end, the infant is a social being right from the start.

Freud actually discovered, early in his studies, the relation of identification to parental and neurotic behavior, but when he realized that his insight meant that the parent had to play a primary rather than secondary role in the development of the child's neurosis and particularly his sexual problem, he could not accept the idea. Freud resolved his dilemma by making identification a developmental phenomenon as well as recognizing that at times it could be a defense. It is my opinion that the parents' sexual use of the child is the source of the child's sexual problem and that it is the basis of the perverse traits that we find in borderline patients. Milton Klein has written a paper (in press. *Bulletin of the Menninger Clinic* I that discusses seduction as a factor in the neuroses and psychoses.

Psychoanalysts have been preoccupied over the years in their efforts to understand identification with questions such as whether the infant "loves" since love for another person is a "high-level emotion" or whether the infant merely engages in "object relations" with empathy or with some small regard for the "other" as a precursor to identification. Sometimes the arguments pro and con regarding love remind one of the old philosophical discussions about how many angels can dance on the point of a pin. The problem of early development is contaminated with various concepts of how the individual emerges from his "narcissistic state" to feel some warmth or "love" for other people. There are many points of divergence among psychoanalytic writers concerning the transition from "pure narcissism" to the state of "object

relatedness." Actually, the infant is "object-related" a few hours after birth. He is "related" and he "emotes" over his relationships with objects. Those authors who agree that the borderline patient has no identification system and therefore is not a person who can care for another and that he has a split ego and therefore is fragile also agree that the transference is a "narcissistic" one rather than one that would be the consequence of identification. The fact is the patient is self-centered out of anger and rage, but he is also "identified" with parental figures.

Kohut contends that the borderline's fragile ego makes the patient psychosis prone due to the lack of a *cohesive self.* According to Kernberg, the borderline is psychosis prone due to a lack of ability to integrate "good" and "bad" introjects. Narcissistic injuries in the borderline, says Kohut, may usher in a regressive movement which tends to go beyond the stage of archaic narcissism, beyond the forms of the cohesive grandiose self and the idealized parental image. This leads to the stage of "autoerotic fragmentation" and the threat of psychosis (an idea based on Freud's developmental concepts and his notion of regression). The individual acquires a schizoid "defense" (Kohut, 1975, p. 27) which is the result of a "preconscious awareness of his fragile ties," but this does not come from the patient's inability to love. Kohut makes a distinction between (1) the "admiration and/or contempt transference," a "lower level transference" with respect to ego organization, being preoedipal in nature where there is not yet true love, and (2) the "love-hate transference"

as in the case where the patient has a “well-delimited cohesive sense of self, associated with a massively introjected internal replica of the oedipal object” and thus a “higher level” ego structure. The borderline patient has the admiration/ contempt transference; because of this, Kohut believes, he cannot tolerate psychoanalytic procedures.

Kernberg uses a similar idea when he says that the “low-level” borderline patient has no identification system since this assumes some “love" for the object. Kernberg, however, apparently does feel that the borderline patient *can* respond to psychoanalytically oriented procedures with supportive measures added. Kohut believes that the patient is capable of empathic feeling, while Kernberg doubts this. Kohut recognizes that in treatment the therapist may feel “tyrannized” by the patient’s expectations and demands; he calls this a manifestation of the therapist as a “narcissistic object" for the patient. I would think that this is obviously a hostile transference based on an identification with the aggressors (parents) who have fostered this type of identification over time. Tyrannization is the sadistic side of the patients’ sadomasochistic transference where the patient is acting out the role of the controlling parent (the obsessive anxiety of the parent) and using the analyst as if he were the guilty child. Kohut contends that in neurosis the adult personality is “impoverished,” and realistic activities are hampered by the breakthrough and intrusion of the “archaic ego structure,” which is related to the suppressed and unintegrated “grandiose

and idealizing selves," the two transferences that must be analyzed. While Kohut speaks of "selves" that have not been integrated, Kernberg considers that there are two "ego states" that have not been integrated. They are "nonmetabolized introjects" that provide the stimulus for the transferences. I believe that the transference is based on the sadomasochistic pattern that develops in the relations with parents, as the parents, in defense, use the child as a transferential object, that is, they use the child as an object of displacement while communicating the kind of roles they wish the child to act out, denying this all the time and demanding that the child also deny that such an identification process is occurring. The borderline patient always acts out the transference in some particular way in the beginning of therapy.

Kernberg considers the aggression that Kohut describes as "tyrannizing" or demeaning to the therapist as "oral." This type of transference does not lend itself to immediate analysis. An example of how patients displaying such transference attempt to involve the analyst in a sadomasochistic pattern at the start of therapy can be seen in the case previously cited in Goldberg (1978, pp. 224-245). The patient tries to interest the analyst in his sexual acting out as an observer, or perhaps one might more accurately say as a kind of Peeping Tom, a role that his parents obviously played out with him. The patient in the beginning of treatment was not engaging in analysis but was trying to seduce the analyst into a sexually perverse game that would knock him out of his therapeutic role.

Many types of patients relate to the analyst in the beginning phase of therapy by playing a sadomasochistic game of some kind, trying to involve the analyst in an interlocking defensive system as he himself was involved by his parents. Many analysts do not understand this kind of acting out in the transference, and when the patient acts toward the analyst in an aggressive way or in an appeasing way to induce him to respond defensively, the analyst's reaction is countertransferential. In the case just mentioned the analyst obviously let the patient know that he was not particularly interested in playing the role of Peeping Tom by listening to the patient's sexual exploits and reading his erotic notes. This was a valid response. The analyst did so in such a way that the patient could understand that he was not being rejected, even though he was acting out a sexually perverse pattern. The relation to the parents was not particularly stressed since this was a beginning phase of treatment. The case was discussed, however, in the Goldberg text in the light of Kohut's theory and the transference was said to be an aspect of the "grandiose self." The implication was that the patient's sexual provocations were really a residual manifestation of a developmental phase, the grandiose exhibitionistic phase, that had been unrequited in infancy. The analyst *should* have reacted as the mother, it was said. I believe he acted correctly in the first place, different from how the real mother acted, not only in the patient's early childhood but how she was still acting when the patient was an adult and out in the world earning his own living. The father, it appeared to me, was in an

interlocking defensive relationship with the mother, an aspect of which determined the patient's preoccupation with sexual matters. Thus the transference could be seen as a combination of mother and father projecting onto the analyst.

Mahler accepts the concept of splitting as a defense in the early stages of infancy, and she supports the Kleinian concept. She believes that splitting drops out toward the end of the second year of life when the major part of the infantile hostility toward the parent is submerged by repression with only a "normal degree of ambivalence" as a factor representing "good" and "bad" internalization of the object. The borderline patient, according to Mahler, has not reached this stage. According to Kohut, in the latter part of the preoedipal period there is a point where the "repression barrier" is formed, between the relatively structured ego and the id. It is during what Mahler has called the oedipal period that the superego is formed, then the repression barrier normally surrounds id, ego, and the superego. For Kohut, Kernberg, Mahler, Masterson, and others the borderline patient has not reached this stage of repression.

The formation of the repression barrier between ego, id, and superego Kohut calls a "horizontal split." He goes on to say that the narcissistically disturbed patient has a "vertical split," which means that the archaic grandiose exhibitionistic self and the archaic idealized self-object are walled

off from consciousness (by fixation), i.e., by dissociation, and *denied* as opposed to the repression acquired normally at the end of the preoedipal period. In “fixation” the idealized object is still fused with the “self" and does not become absorbed in the ego as in normal developmental procedure. The self-object remains as a separate entity expressed in fantasy that interferes with healthy “narcissistic development.” As a consequence of the “fixation,” the “grandiose exhibitionistic self” and “archaic or voyeuristic idealizing self-object” are evoked in treatment in the transferences projected onto the analyst. Kohut states that actually this is not transference in the ordinary neurotic sense of the word *since the analyst is a self-object*, part of the patient’s “self." It is as though the analyst were a “body part," having no separate existence. The “mirror transferences," such as (1) the merger—“the self-object with the grandiose self"—and (2) “the twinship" —the alter ego of the “mirror" in the narrow sense of the word, functionally are to be understood in the developmental sense in ascending order. The transference proceeds from the “mirror type” to the “idealizing” phase, and there are alternations of the two. The analyst acting as the good or perfect mother gives the patient the opportunity to experience the normal developmental phases that the patient missed, as an infant and young child, thus enabling him to absorb the bifurcated “selves" into the *real self* and further develop the ego, removing the “vertical split" and transforming the primitive narcissism into the more mature forms. Apparently, this can happen only with the narcissistic

personalities and not the borderlines. The latter remain “split” and cannot tolerate the analysis of transferences (Kohut, 1971, p. 220). In analysis the “primary defect” in the structure of the “self” is healed by the acquisition of new structures through “transmutting internalization."

Kohut believes that in childhood borderlines try to cover up their depression through erotic and grandiose fantasies. They try “self-stimulation” when the appropriate kind of stimulation is not forthcoming from the mother. I believe that the parents do stimulate the child sexually through their perverse habits and that there is a sexual response on the part of the child. The parent's stimulation or sexual use of the child changes as the child grows older, and the projections or the displacements seen in the sexual acting out with the child take many and varied forms. There is also a nonsexual use of the child, that also leads to acting out of an identification role, a denied role. There are various forms of projection in both types of transferential use of the child (a projection is a denied form of transference). For the borderline patient there is both verbal and nonverbal communication to indicate the kind of role that the parents project. There is, for example, the monster, the idiot child, the pervert (and there are various forms of this perverse behavior), the girl who acts like a boy, the boy who acts like a girl, the liar, the cheat, and so on and so on. The results of these projections are particularly noticeable in homosexuals (who tend to sexualize most relationships), in patterns of excessive masturbation, in fantasies of pederasty, and so forth.

The mental defenses against these acted-out patterns are found in romantic ideas, in demanding notice from others, in fantasies of weakness, in hypochondriacal fantasies.

Internalization, Psychic Structure, and Character Structure

The problem of understanding how experience becomes registered in the mind, how it relates to development, and how this influences the possibility of "good" or “bad" relations with others has been explained in many ways from the psychoanalytic point of view, but the basic premise involves the processes of *identification* and *internalization.* There is presumably a “normal" form of identification. In the earliest phase of development this process has been conceived of as “incorporation,” in the next phase as “introjection," and finally as “identification." The most confusing concept in this theory is that of incorporation, a special form of introjection. It is a taking into the mind the attributes of another person in the sense of “orally engulfing these and swallowing them." A change in personality occurs, and the person becomes like someone else by “fantasied oral consumption" (Moore & Fine, 1968, p. 52).

The theory of how the “external” (experience) becomes a mental representation is delineated in the concept of *internalization.* There are two definitions of internalization, a very broad one and a more narrow concept

that is, in fact, similar to a conditioning process (Moore & Fine, 1968, p. 57). Each has a basic tenet, however, a concept of relationship with objects and the idea of substituting or incorporating "inner for outer controls." Spitz (1966) spoke of the "no-yes" phenomenon as being an important first step in this process, which involves the mother and her permissions and prohibitions, an idea similar to Kohut's. The concepts, on the group level, of survival of the species, social institutions, and interpersonal relations and, on the individual level, of memory, symbol formation, decisional phenomena, thought, fantasy, isolation, and projection are all involved in the broad definition of internalization. Thus there is a plethora of concepts and a great confusion of ideas. As a result, information from one discipline becomes misapplied in another. It is also in this area that the individual versus the group becomes a conceptual difficulty. The developmental system and its various universes (physical, mental, genetic) have been translated and retranslated into various "scientific" schemes. Social institutions are conceived of as being in the broader "no-yes" category representing the guidelines of society with respect to cultural norms. Such an idea is only partly correct, for not all social institutions represent the best norms for behavior in the society. Like fathers and mothers, social institutions can be "good" or "bad" or a mixture of both good and bad. Durkheim introduced the concept of "collective representations," social institutions being one aspect of the entities that are in toto the "culture" of a given society. When Freud

decided that psychoanalysis could explain society as well as the dynamics of emotional disorders and the treatment thereof, he went into speculations that sociologists and anthropologists could not accept.

According to Schaefer (1968, p. 9), internalization means all those processes by which the subject transforms real or imagined regulatory interactions with his environment and real or imagined characteristics (of others) into "inner regulations and characteristics." One can see that the autonomous behavior, the creative process, problem solving, or learning by one's self are not stressed here; what is favored are imitation, conditioning, and identification. Learning from repetition through the admonitive behavior of others seems to be the essence of Schaefer's concept of internalization. Schaefer first alleges "object" and "self" are one. Then from 8 to 13 months of age (at 7 months the infant has left the period where he will accept anyone as mother) the mother becomes the focus of the infant's "object relations." As yet, the infant has not established a lasting memory of the mother in a way sufficient to soothe him when the mother is not there, but he has transitional objects (people and things) that he can use as her substitute. Around 15 months (the first part of the rapproachment subphase) change that has been gradually accruing over time is seen in force in the child who tries to feed the mother and give her gifts, acting toward the mother as the mother has acted toward the child. This process began in rudimentary form between 8 and 13 months in the "no-yes" process (in Piaget's Stage IV [1954] and Mahler's

separation-individuation phase [1971]). When the mother leaves the infant and comes back and when she says “no" and “yes,” these experiences make him understand some of his separateness; he begins to say “no” and “yes” to others.

Various writers have placed the capacity to experience or recognize self from 2 months to 2 years. Spitz proposes that in the “no-yes” period, identifications begin, both identification with the “aggressor” and identification with the “good object” so that the “good” and “bad” object concept takes form. Identification means acting like the mother with regard to behavior related to “yes” and “no.” Some modern experimenters, on the other hand, believe that self-awareness begins at 3 months (Caplan, 1973, p. 85).

Kohut, as has been indicated, also emphasizes the importance of the character of the mother rather than the instincts of sexuality and aggression as do Klein and Kemberg. They place little emphasis on the characteristics of the mother or the influence of the environment; they stress, instead, the infant’s own defenses, or lack of them, against the instinct of aggression.

We have mentioned that psychoanalytic developmental theory emphasizes the change that occurs between 7 and 15 months of age. According to the theory, this includes the important transition from a feeling of omnipotence that the infant has as the mother administers to him in his

“need satisfying period" (i.e., the period when the infant conceives of his mother as an extension of himself) to the “separate” but “weak feeling” that develops as the infant recognizes his helplessness and develops a high consideration for the object. Around the eighth month the child has begun to suffer some “separation anxiety,” but he is able to soothe himself with “transitional objects,” (such as a teddy bear, or toys, or a blanket) and with brief memory or fantasies of the mother. Some analysts utilize Piaget’s idea of Stage IV (around 8 to 13 months), where the infant will look for a toy if it is shown to him and then hidden, to establish the age when separation begins to take place. It is not until the end of the sensorimotor stage (18 months), however, that a true sustained mental representation of the mother is presumed to be present, according to Piaget (1954). In the period up to 18 months the child has learned to soothe himself by substitute objects and fantasies. Piaget puts the beginning of the “appearance-disappearance” phenomenon at 8 to 13 months. In the beginning the infant will look for a toy if it is hidden, but it may be only at 13 months (perhaps 12 to 15 months) before he will actually find the toy. When he is able to locate the toy, this will mean that he will have reached a state where he can keep the memory of the toy in his mind long enough to search and discover. This, then, ushers in the period of object constancy and object permanence.

Some authors believe that the period that leads to object constancy also is the beginning of the secondary stage of narcissism. It is perhaps important

to remember that it is at this 8 month period also that the phylogenetically determined fear response is said to come into operation.

The borderline, Kernberg insists, is different from birth by virtue of his aggression. Anger is his basic emotion. He is unable to *relate* to people due to his aggression, but it seems to me that the capacity for relationship is a "given." By the age of 2 months the infant is immensely aware of human beings when they are in his presence. We do not know that the borderline patient is any different from other children in infancy. Actually, shortly after birth the infant relates and is emotional in the relationship with others. Plutchik 11962, 1970) has been working on a phylogenetic theory of emotion. In the case of aggression he uses the word *destruction.* A low degree of this emotion would be "annoyance," a more extreme form "anger," and the most extreme form "rage" (Kellerman, 1979, pp. 32-33). I believe that the aggression has an instinctual base, but as Harlow (1976) and Eibl-Eibesfeldt (1974) suggest it must be stimulated by external forces. We must remember that in the most final stages of defense "rage" becomes converted into *revenge feelings* in the borderline condition. The individual gets back his self-respect through revenge. It is the degree of frustration-aggression that is stimulated in the situation that is the basis for understanding these various degrees of aggression. One of the most distressing effects of aggression is in the symptoms of masochism. Masochism may be attenuated if the individual is able to strike out actively at someone else. The young child, however, will hit

at himself if he is restrained from striking at a person in his anger, and this reaction can be encouraged by parents who are defending against or denying their own aggression.

It is my belief that the more restricted definition of “internalization” refers to identifications with *parental figures*, which in the case of the borderline patient, are aspects of the parental neurosis that are projected onto the child as a role which he is impelled through pimishment and reward to accept. The “internalization" is a learned response to the neurotic needs of the parent. This is a special case in learning. All other internalizations, I believe, should simply be called responses to the environment or *learning,* which includes all that the person absorbs in relations with others or with any type of “object.” In psychoanalysis we are interested primarily in the learning that has to do with developing neuroses and psychoses and with the autonomous behavior that helps to resolve these difficulties. In masochism one finds a great deal of “self-reference,” the opposite being the grandiose feeling of self-importance, associated with sadistic impulses.

Self-Reference What is called *self-reference in interactions with others* and a need to be admired and loved is considered to be an “unmetabolized" aspect of a primitive self-object, a residual of what Kohut sees as a normal development gone wrong due to the deficiencies of a neurotic and/or psychotic mother. Kernberg attributes the problem to a genetic defect

evidenced by a split in the mind which deprives the patient of the ability to integrate the good and bad of objects, the patient having haughty, grandiose, and controlling behavior toward those from whom he expects little and an idealizing attitude toward those from whom he expects most. The haughtiness and grandiosity are defenses, according to Kernberg, against paranoid traits that emerge due to the projection of innate oral rage. The main defenses against oral rage are splitting, denial, idealization, and omnipotence. There are also periods of derealization and depersonalization that are frightening to the patient because they blot him out, as well as his surroundings, for brief periods.

It seems to me that “self-reference” means, “Bring the focus back to me.” This furthermore means, “Let me control the situation; otherwise my defenses will be penetrated and you will harm me.” Also “If I lose my control over you, I will have to face myself, which I do not wish to do. You must play the game my parents played with me for this is how I survived." There are fears of engulfment if these defenses are disturbed. If the individual gets into a close or intimate relationship, he will have to be submerged in the other person as he was with his parents. He defends against that possibility. *Twinship,* as Kohut uses the term, apparently can mean identifying with the illness of another person; or it can indicate a normal relationship. Being “submerged” is interpreted to mean that the borderline patient has not left the symbiotic stage of development. To me, “submerged” means that the

individual has, over time, accepted the sadomasochistic position and he finds he cannot, due to his guilt, step out of that kind of role. His anxiety would be too great if he were to act in a more normal or rational way. It is not that he is not "separate," for he acts in many ways as a separate individual. It is that his conditioning is sadomasochistic, and even though he wishes to give up the pattern, his guilt causes him so much anxiety that he hesitates. Coming for therapy, however, is a first step in the effort to relinquish the sadomasochistic pattern.

"Self-reference" is associated with fear, suspiciousness, paranoid feelings, fears of engulfment, counterphobic mechanisms, inhibitions, and so on. These are the kinds of characteristics that Chessick, Modell, Odier, and Leuba describe. The implication is that the patient has been so disappointed by the parents and their lack of regard, their lying, and their deceits that he is suspicious of everyone. These traits would be associated then with transference feelings. The patients would not trust anyone suspecting that everyone would be like their unreliable parents. It has been my experience that borderline patients are not so suspicious as to remain aloof from people. They do have relationships and primarily with members of the opposite sex. They are not loners, or isolates, although their relationships are of a sadomasochistic nature.

Revenge There are many ways that the borderline patient acts out the

revenge problem in the transference with the analyst. The patient also has *fears* of acting out revenge. Daird (see Wolberg, A., 1973, p. 174) was afraid he might attack a child sexually, and George Frank Quinn (p. 172) feared he might strangle his girlfriend. Revenge can be evident in passivity and "spoiling" (undoing?). For example, one patient (passively) made innumerable mistakes as an editor and let books be printed with errors in the hundreds. There are certain patients who confront the analyst with their open aggression from the beginning: they deride, taunt, attack, and demean. I am inclined to view such overt attacks as symptoms of schizophrenia rather than of borderlineness. Such patients have definite paranoid trends that are persistent rather than fleeting, as in the case with borderlines. There are certain patients who express the idea that they wonder if the analyst can "take it," i.e., can survive their aggression. If one believes, as Melanie Klein did, that the mother must "withstand" the infant's aggression if both are to come out of the parent-child relationship intact, then one could see a parallel between the "battering infant" and the patient who as an adult beats verbally at the analyst; but Klein's idea seems farfetched and unrealistic. It is the parent who projects aggression onto the child rather than the infant who reacts with raw innate irrational rage.

Fears of Annihilation and Abandonment in Relation to Aggression The patient's efforts to hold onto his "grandiose self" (I consider this an aspect of his sadism or revenge feelings) and his efforts to avoid acknowledging the

analyst as an independent autonomous person, according to Kernberg, consistently reveal his defenses against (1) his "intense envy," (2) the feared relationship with the hated and the "sadistically perceived mother image" (his projection), and (3) his dread of the sense of empty loneliness were he to be separated from his object, a contingency that the patient feels would create for him a world devoid of meaning. Behind the "disappointments" in the parents is the "devaluation of the parental images." Devaluing the analyst in an effort to eliminate him as an important object who would otherwise be feared and envied because the patient is so dependent and so desperately needs to rely on an object is a characteristic function of the rage reaction, according to Kernberg. It would be my thought that the patient would hang on to his rage in order to defend against his masochism, which is a function of devalued self-esteem. In this way he can avoid the feeling of having been *used* and therefore *rejected* as a person in his own right by his parents; he can seek out a sadomasochistic relationship with the analyst (in transference) and with others to help sustain yet contain his anger and revenge feelings. The patient fears being alone, according to my view, for he will then turn his aggression on himself. It is true that the patient has envy, but this is envy of others who do not have the *inhibitions* that he has or who are not driven by revenge feelings and sadism. I do not agree with Klein's proposition that envy is a function of an early stage of infancy.

Masterson (1972, 1976) has written several books on the borderline

patient. He has elaborated his ideas about adolescent borderlines as well as the adult patient. His general thesis (Masterson, 1976) is that the mother is threatened by and is unable to cope with the infant's emerging individuality due to her fears of abandonment; therefore, she clings to the child to prevent separation, discouraging moves toward other individuals by withdrawing her support. In relation to this idea, he has a scheme based on some of Fairbairn's concepts (1954) concerning a "withdrawing object relations unit" (WORU) and a "rewarding object relations unit" (RORU) and the transferences expressed in the service of the relations to these objects. Fairbairn spoke of (1) the tantalizing mother, (2) the rejective, angry, authoritarian, antilibidinal mother, and (3) the emotionally neutral, morally idealized mother. "Ego splitting" was a reaction to the experiences with these mothers. (The same designations I find can be attributed to the father although each parent has his own unique combination of these characteristics.) The idea of special relation with the mother is reminiscent of Kohut's idea that the mother reacts either positively or negatively to the infant's "grandiose self" and that this has a relation to high or low selfesteem. This seems a rational thesis, but I believe we should include the father as well in this picture. It is not the mother, per se, but the *family group and its defensive system*, *including the special rearing techniques used*, *that are the important conditioning factors.* Is it not possible that the parents fear abandonment due to their need for an object upon whom to express and project their rage and revenge feelings? Does not denial

occur because of the fears the child has of the parents' aggressions and his own counteraggressions, and the dangers these pose?

Like Kohut and Kernberg, Masterson considers the borderline patient psychosis prone and cites the kind of situation that he believes might “throw" the patient over the border. He says, for example, that a patient might attack the therapist by projecting on him the WORU image of the mother. If the therapist is passive, as in classical psychoanalysis, the therapist's action will “so correspond to the patient’s projection of his withdrawing maternal part-image that the patient will not be able to distinguish between his WORU projection and the reality of the therapist’s behavior. Consequently, he may enter a transference psychosis. This will activate the RORU unit which the patient has denied and experienced as egosyntonic so it will produce resistance and therapy will stop” (Masterson. 1976, p. 108).

Unlike Fairbairn, Freud could not credit parents with “blame" for the child’s emotional problems. Most analysts today “blame” the mother for the borderline’s difficulties. The only passage in Freud’s writing I have discovered that refers to the possible hostility of the parent and the counterhostility of the child, is in the essay on “Female Sexuality” (Freud. S. E., 1931, p. 237). There is no reference to the “unconscious hostility” of the father. Fear of the parents may well be the source of the child’s first projections and displacements, and it is certainly the basis for his identifications, especially

those that impel neurotic behavior. But I believe that the projections or fantasies of the father must be considered as well as the mother's fantasies, recognizing the interlocking defensive system between the parents (Wolberg, A., 1960, pp. 170-184; 1973, pp. 102-114). The *fantasies* become a stimulus for the acting-out patterns of the borderline patient, and they are activated in situations where the individual has felt demeaned.

Fenichel (1945) suggested that the neurotic person has a fear of *annihilation.* This seems a likely possibility in the borderline since it is the *aggression* (the patient's own as well as the parents' and the aggression of others) that creates fear and the need for defense. Before the destructive tendencies are worked through, the borderline patient dreads being alone with his own destructive fantasies since he fears turning on himself, or running out to find another person (a stranger) with whom to act out. Turning on the self (displacement) in the absence of another figure is a mechanism that may be genetically determined and related to frustration. When birds are frustrated, they turn to displacement behavior; the same is true of animals. When infants and small children are frustrated from expressing anger, they turn on themselves in fury (see Wolberg, A., 1973, note 2, pp. 123-124). Harlow's (1976) frustrated monkeys showed these tendencies, too. Freud mentioned this kind of reaction on the part of children.

It may well be that the child fears annihilation from the parents as they

express their aggression, especially in the early years (from 1 to 5), and that is why fears and aggression are exaggerated and disguised in dreams and fantasies. The feelings of annihilation, according to some psychoanalytic theorists, are due to fears of separation from the mother. I suggest that such a fear is based on the knowledge that the parents' aggression is dangerous and certainly forthcoming if the child steps out of his assigned identification role, just as Roxanne had need to fear but, nevertheless, tried to save herself, even at the age of 3 years (see Wolberg, A., 1973, pp. 12-13).

In my opinion, the child's feelings of danger are based on fears that love is a tenuous and feeble matter and is no safeguard against annihilation by aggression. Freud thought that every type of fear is related to anxiety and that all anxieties are based on an original prototype of danger, but the *content* of the fears of danger change as the individual advances in age. "Loss of love" inspires guilt feelings in the child. One who does not receive love is a hated person, thus a "bad" person who does not deserve love. There is ambivalence, however, in the borderline patient, for he is not completely rejected. He is sufficiently rejected, nevertheless, to arouse not only fear but also rage and revenge. And he fears his own rage. Thus, my patient James Weber, a psychologist, feared he might not be able to function with patients due to his withdrawal and detachment defenses and his impulse to tease and express aggression (revenge feelings). He was correctly seeing these traits as a detriment in establishing a working relationship with patients and with other

people as well. At one moment he felt he could never be free of these traits and thus would need a supervisor for the rest of his life if he were to become a therapist. The supervisor would protect his patients by keeping him in line. He often attempted in the analysis to make me into his supervisor rather than allowing me to be his analyst. At other moments he felt capable on his own.

Masterson (1976) speaks of the “reunion fantasy" as an aspect of the RORU transference. Kohut has a “reunion” concept in his “fusion" and merging idea. Kohut sees the “reunion” as fulfilling a need that has been unsatisfied—it is expressed in a longing for a mother who can help create the needed ego functions. This is related to self-reference and narcissistic feelings. While it is true that the borderline patient’s mother interferes with the child’s autonomous and self-actualizing behaviors due to her conflicts and anxieties, the father does this as well. In each case the parents interfere either by activity or through default or by both kinds of behavior. On the surface it might appear as though the parents need a substitute figure for their parents in the child. But, this “need” is not like a need that is carried over from infancy due to some ego defect; rather it is the consequence of the fact that the parents require a sadomasochistic relationship (defense) with the child in order to perpetuate their neurotic homeostasis by projecting aggression and revenge feelings and acting them out. The parents do not wish the child to get beyond their grasp. The child not only represents the projected identification with the parents' mothers but *with their fathers as well.* These “images,” I

think, are not “infantile images” that are “unmetabolized”; they are reflections in fantasy of the kind of relationship the mother and father had with their parents over time. This means, as a rule, throughout infancy, early childhood, and adolescence and often into young adulthood. The “images” (fantasies) represent among other considerations. the acting-out roles (identifications) that have been demanded by the parents.

Masterson makes a salient point in saying that *activity* is an important aspect of treatment with these patients. I believe that the activity must be geared toward certain goals: (1) asking questions that lead to a delineation of the interlocking defensive system. (2) outlining the identification roles, (3) depicting the guilt-ridden, masochistic attitudes that are always present when the wish for normal pursuits occurs. Later questions should refer to revenge, sadism, perverse sexual feeling, and the fears of giving up neurotic relationships. We find in borderlines fears of making new kinds of relationships, fears of abandoning people the patient has known and been close to (i.e., fears of hurting people by giving them up), and fears of retaliation from people who may not wish to be abandoned. In dreams giving up attachments to neurotic parents is often depicted as killing someone or some animal, or perhaps watching someone else kill, or perhaps knowing that someone is going to be killed. Giving up the sadomasochistic relationship is *felt* as an aggression lor perhaps it is *feared* as an aggression), as a blow to the parents. The “reunion" would then be a return to the sadomasochism out of

fear of giving it up.

Thus when Masterson speaks of the “reunion fantasy,” he is really talking about a sadomasochistic fantasy of passivity. It takes place after the patient has experienced fear in associating with others due to his own feelings of aggression or after he has had to deal with aggression in others. It is a return to the masochistic role similar to the one he had with the parents rather than a mother-child type of reunion due to a fear of separation such as the child might experience in the 12- to 16-month stage. A masochistic feeling (a feeling of humiliation and low self-esteem) usually precedes an acting-out episode, as was illustrated in my session with George Adler (Wolberg, A., 1973, pp. 216-219). When I pressed George to go on with his fantasy, he said he had a fantasy of choking his senior colleague, who seemed to be in competition with George at inappropriate times. (It was fear of choking his girlfriend that brought him into treatment.) At that time he was locked in a relationship with a girl who was quite sadistic and tantalizing due to her own problem, particularly her fears of sex. The “reunion fantasy," I believe, is actually a form of the *identification fantasy* and a defense against acting out murderous feelings either against others or on the self. The person feels that the other is teasing or being sadistic. George Frank Quinn had this feeling about his senior colleagues; the colleague was teasing, being controlling and hostile, like his parents. He had this feeling in transference. When he went out from a session, he sought a homosexual partner la person he did not know) so

as to act out a revenge motif.

The reunion fantasy is a sadomasochistic bind that is being acted out. In relations with the parents the patient is a projective object in order that the parents may express their aggression in various forms, in this way avoiding feelings of anxiety that they would have were they forced to face their real feelings about themselves and their children. If the mother feels "abandonment." then it is due to the *anger* and *depression* she would have to face and analyze in a confrontation of her own neurosis if she did not have the child as a foil. I would see what Masterson calls "fear of abandonment" and the "reunion fantasy" as a need to retain a defense against aggression due to a feeling of humiliation. The mother would have to admit, in a confrontation, the fact that she is using the child in a neurotic way and that there are sexual (perverse) as well as nonsexual aims in the behavior. The same would be true of the father. The patient would have to face his identification pattern with the parents. The sessions with James Weber (see Chapter II) are illustrative of these problems, and his resistance to working them through is typical of the borderline who has a need to hang on to his aggression to protect his identification. The anxiety is often so great that the individual fears he will "go to pieces" if he cannot express his aggression.

We have mentioned that Kohut believes the borderline patient cannot be analyzed because of his intense anxiety and fear of collapse. Some patients

do collapse; that is, they have a psychotic episode rather than face the facts of their sadomasochism. *The psychotic attack is thus another kind of defense* and one that puts a stop temporarily to the therapeutic endeavor except insofar as hospitalization can become an aspect of the treatment procedure.

In his paper "The Question of Family Homeostasis" (1957) Jackson wrote of the need for the parent to bind the child so *that the parent would not lapse into a psychotic episode.* Apparently, the parents did not mind if the child became psychotic and had to go to the hospital. The child could escape into psychosis. But if the parent became psychotic, the burden of guilt would be on the child for not doing as the parent wished. In such cases I feel that the psychotic episode is in the nature of a temper tantrum and revengeful act. The parent is angry because he has lost control of the other and can no longer receive the bounties of the sadomasochistic position. In the case of the child, punishment and guilt create the aggression that is defended by the psychotic episode.

Intrapsychic Symptoms Chessick (1977) has made some comments on the work of Kernberg and Kohut in contrast to his own ideas. He asserts that the borderline patient has an *intrapsychic defect* (rather than developmental arrest) grounded on massive failure in the maternal environment. His internalization of objects and thus his narcissism and introject formation are related to setting up his own *substitute structures* in order to deal with

aggression and other drives so that he can achieve some kind of adaptation to life. One could say that Chessick agrees in part with Kohut and in part with Kernberg. I suspect that the term "substitute structure" refers to fantasies, which in the context that Chessick uses the phrase would mean the same as what I call the "identification fantasy." Chessick believes that the patient's fantasies are later elaborations; they are attached to ideas and feelings that occur after infancy (Chessick, 1977, pp. 111-112). This seems a factual way of looking at matters.

Chessick distinguishes between the borderline syndrome and the narcissistic personality disorder by saying that the latter has achieved some *internalized psychic structures,* although these are primitive. The former, on the other hand, has an *intrapsychic defect.* (Here again, we see similarities between Chessick and Kohut.) The narcissistic personality is responding to a failure in the maternal environment that is more subtle than that experienced by the borderline patient. Disillusionment with the mother, according to Chessick, is the central factor leading to substantial "developmental arrest" in the area of narcissism. I have found that the borderline patient is disappointed in both parents. The child has hoped for rescue. If the mother is more controlling and sadistic, the child hopes that the father will rescue, and if the father is more punitive and rigid, the child hopes for rescue from the mother. Since both parents are locked in a sadomasochistic defensive relationship, true rescue comes from neither side.

The treatment for *intrapsychic defect* should be different from that for people with *developmental arrest*, contends Chessick. We must not confuse *defensive structures*, he says, with "*pristine or archaic psychic structures"* as they manifest themselves in the personality and behavior of our patients. Chessick's phrase "intrapsychic defect" in a borderline must be a way of considering a problem within the context of the structural hypothesis, in relating to the early stages of organization of the id, the ego, and the superego. "Developmental arrest" seems to refer to the idea of *fixation,* and yet all of these authors (Chessick, Kohut, Kernberg, Masterson, to name a few) speak of fixation in the borderline patient. Fixation, however, seems to imply the presence of a basic psychic structure as in developmental arrest, while intrapsychic defect means something is missing mentally.

Fixation is a nebulous concept. Moore and Fine (1968, p. 47) suggest that there are "unknown constitutional reasons" for fixation such as "inherent differences in the functioning of various erogenous zones" and in "ego givens." In fixation there is an *immature ego* that can be overcome by "too much stress." Kohut (1971, 1977) has explained this difficulty by means of his social psychological theory concerning the conditioning of the child in his relationship with an unresponsive mother. There is no "quieting internalization" possible, for the mother has not comforted the child in times of stress. In defining fixation, Moore and Fine (1968) also speak of "arrests of development" in both instinctual and ego-superego organization. These

“arrests” cause primitive ways of relating to people and a form of defensive reaction that was used in what were considered to be early dangers. The defenses are later outmoded but are still used. “With disturbances of subsequent development and conflicts over contemporary functioning” the individual may *regress* to the “remnants of earlier functioning" that are “fixed in the psyche.” Kohut’s theory states that the child “internalizes the functions" that the mother performs. In this interchange the infant “idealizes" the object (the mother) that he both loves and fears. As the infant “idealizes,” the ego ideal begins to form. Mahler (1971) agrees with Freud saying that the impetus for idealization stems from the infant’s experience in walking. As he begins to walk and realizes that he needs the object for this period, he loses his feelings of omnipotence, which are gradually replaced, and the infant now feels helpless. This causes him to develop an idealization of the parent, whom he now conceives of as strong. He begins to overcome his helplessness by identifying with the strong person and by internalizing the controls that the parent was forced originally to impose.

Chessick comments that Kernberg has referred to “pristine structures” as “substitute structures” in the form of fantasies of power, wealth, and beauty that compensate for the experience of severe frustration, rage, and envy— the compensation being idealization of the object by a fantasy of an ever loving and ever caring mother in contrast to what exists in reality. As I have said, it is most improbable that infants have fantasies of power, wealth,

and beauty: these are obviously concepts that refer to the desire to control others in particular ways. The concept of an "ever loving mother" is, in reality, an idealization of a mother who binds the child in a sadomasochistic way, constituting a defense in the face of a parent who does not rescue. My interviews with James Weber touched upon this problem (see Chapter 11).

The relationship between the child and each parent is sadomasochistic as a result originally of the problems of the parents. Both the parents and children are bound together, psychologically speaking, out of fear, guilt, and rage—not from willingness to love or to be helpful to one another. In this type of relationship there is hostility and a sadomasochistic game that is played out in the family. The parents know that they should love and often they accomplish what Chessick speaks of as "pseudogiving," i.e., they give out of guilt or they overprotect. This kind of interaction with parents is denied and idealized. Distinctions can be made between the father and mother transferences as they repetitively crop up in the treatment situation. once the working-through process is well under way. In treatment there is an analysis of the fantasies so as to have eventually a confrontation about the reality situation that existed and that still exists with others.

If one were to summarize Chessick's concepts, one might say that the borderline has no true identification (in the positive developmental sense according to Freud's idea of the composition of the ego) with the parents and

hardly any introjects (Kernberg and Erikson) in the early stages of development so that he utilizes fantasies (substitute structures) that take the place of what is lacking in the form of early ego and superego formation. He incorporates his experiences with his parents into his fantasies at a later stage and can develop identifications of a kind in this later period. He can differentiate self from object at later periods. Chessick here differs from Kernberg. Kohut. and Masterson. They seem to feel that the borderline patient has no capacity for “separation” because emotionally he has not passed through the developmental stage of “object constancy” where it is possible to have some rudimentary forms of interpersonal empathy and some early indications of superego structure. The latter has to do with what Clark called “secondary narcissism" and what both Clark and Mahler refer to as a relationship based on some consideration for the “needs of the object.” Chessick believes that the “unmetabolized aggression” is an interference with an adequate way of coping with life and relating to people and that analysis requires an emphasis on the *intrapsychic defects* as reflected in the fantasies. The id. ego, and superego are defective or have deficits, that are seen as “archaic psychic structures.” Idealization is one kind of defect, and rage is another defect. Grandiose fantasies are also indications of a defect that prevents a resolution of the rage and idealization.

According to Chessick. the borderline patient's “primitive affect” is founded upon the development of enormous “undifferentiated primitive

rage." However, he says that in the borderline patient we see this represented through ideation that is organized in a later phase of development at a time when there is adequate cognitive capacity, including the capacity to form, retain, and represent self- and object-images, but the enormous undifferentiated primitive rage (affect) disrupts the development and the smooth functioning of the psychic apparatus. The negative affect is later attached to and appears clinically in fantasies and projections of destructive. archaic, bad, unintegrated self- and object-images. Both "intrapsychic defect" and "developmental arrest" are due primarily to lack of strong positive identifications that neutralize and modify aggression. (It is certainly true that anger and rage prevent the individual from responding adequately in an interpersonal relationship. This can be seen readily in the interpersonal encounters within the therapeutic relationship. One sees anger as inhibitive both in the case of the patient, and counter-transferentially on the part of the analyst if anger is evoked in him. In this latter case when anger is stimulated, the analyst is often not able to understand the negative therapeutic reaction.)

Chessick contends that the borderline uses his fantasies to deal with his *innate aggression and other drives* so that he can achieve a form of adaptation. Are the fantasies then a substitute for a rudimentary ego? Or are they *defenses* while at the same time *they contain reality concepts that form the basis of the ego?* I would think that these fantasies would contain forms of *defense,* forms of escape, forms of dealing with anxiety, forms of denial, and distortions of the

reality against which the defenses are utilized. *Reality concepts do exist in the fantasies.* (Actually, reality constructs are present in the infant's mind even at the age where Kernberg conceives of a defense of splitting. 1 to 24 months. I Freud mentioned that fantasies could be a denial of the feelings of danger concerning the parents, the fantasies being substitutes for the parents. I think of the fears in the fantasies as *precursors* to later identifications with aggressors (the parents). As the individual gets older, the fantasies become more complicated, and so in the mind of the borderline, as we have repeatedly stressed, they represent the sadomasochistic relationship with the parents. The fantasies represent the disguised reality of the sadomasochistic relationship the patient has throughout his life with other people, but they are also defenses against the reality (traumas) of the interpersonal relationships with parents.

We have noted that Kernberg has proposed that the pathology that "fixates splitting" and prevents its replacement by "more mature defenses" is the consequence of "nonmetabolized early introjections which later come to the surface, not as 'free floating' internal objects but as specific ego structures into which they have crystallized." Fixation occurs in the period from 6 to 14 months. Apparently the "ego structures" to which Kernberg refers are the fantasies of "power, wealth and beauty," which would be related to grandiose mechanisms. In my opinion these fantasies would have to be later elaborations, as Chessick suggests, since the infant would know nothing of

control by such factors. The beginnings of such fantasies would be the fears of unknown things or of animals. Much later the idealization of the fearful objects can be seen in dreams. *Actually idealization is a form of "remaking reality, "* but this too would be a later elaboration, at 5 years or older, when the "family romance" would be organized. Prior to this, one finds the "beating fantasy" (occurring first about the age of 4), which then persists in one form or another throughout development and into adulthood.

The timing of the crucial period of fixation at which the borderline pathology precipitates has been a subject of controversy and debate among different authors. For example, Chessick says that Masterson and Rinsley (1075) agree with him that Mahler's rather than Kernberg's timing is more attuned to the facts. Kernberg places this time in the period of 4 to 12 months, while Mahler favors fixation at 16 to 25 months coinciding with the period of the "rapproachment subphase." Kernberg considers his Stage III the period of fixation (6 to 14 months) before the period of "object constancy."

When Chessick says we must not confuse *defensive reactions with pristine or archaic psychic structures,* I take this to mean that he has in mind psychic structures formed in the period of 2 months to 16 or 18 months that correspond to the period of what has been called "the oral triad" (Moore *&* Fine. 1968. p. 68), which is described as a *developmental phenomenon* that can be related both to the *self* (the ego) and to the *instincts.* Psychic structures,

according to this way of thinking, are different from defenses: they are *representations of the instinct and of the self* that become attached to ideations in early periods and they are found to be present presumably in later periods when the id, ego and superego became solidified, as postulated in the structural hypothesis. The theory is, for example, that when the teeth begin to erupt, it constitutes the psychological basis for *oral aggression* or *oral sadism.* The appearance of the teeth ushers in *oral drives* that are motivated by the *aggressive instincts,* which express themselves in chewing, biting, and spitting. When problems arise in the so-called "oral stage," they are said to be the forerunners of later character problems, such as greed, demandingness, restlessness, as well as forerunners of traits that are completely opposite, such as generosity and penuriousness, dependency and independence, and so forth. Practically speaking, eating and later chewing are normal activities that have no intrinsic relation to aggression and sadism. Anal activities are prominent and present at birth as well as oral activities, and they create as much need for maternal attention and pose as much possibility for relief of tension and pleasure as feeding. "Oral activities" are also forerunners of the later abilities for speech and facial expression, important communication functions.

When Chessick says that narcissistic personalities have "developmental arrest" while borderlines have "intrapsychic defect", this seems to mean that *arrest in development* implies "fixation" which can occur in the ego-superego

formation and thus in the development of the “self” (this would require *defense* I while in the borderlines the *structural process is defective* so that the id. ego, and superego do not form a composite organization or do not reach an equilibrium. The latter has to be achieved in therapy. Both Kernberg and Kohut, on the other hand, feel that in the narcissistic disorders there is a “cohesive self” (Kernberg would say “ego”) and therefore there must be basic intact archaic psychic structures. Kohut says that the *self* is the mediating factor or the “switch” that puts the ego into operation. The borderline's ego and the substructure *self* are defective: that is, they do not have cohesion or an organization because the *fantasies (at 16 months?) do not hold down the aggression to a point where the individual can get along with others without gross symptoms.* What are these symptoms? Grandiosity and low self-esteem, according to Kohut and Kernberg.

Chessick discusses similarities and dissimilarities of various authors who concerned themselves with developmental phenomena by reconstructing these, as Freud did, from psychoanalytic data. For example, he finds that the “no-self-object differentiation” of Modell corresponds roughly to Freud's stage of “primary narcissism" and is the same period as Mahler's “symbiotic phase" (2 to 6 months!. Chessick also points out that Freud's phase of “object love" is like Mahler’s “separation-individuation" phase 16 to 24 months). (We know that Freud postulated overlapping phases. For example, the oral phase extended to 18 months, but the “object love phase" was

included in the latter part of this stage. The stages of primary and secondary narcissism were included in this time span as well.) Chessick reminds us that Kohut sees the development of primary narcissism as occurring from 6 to 10 months, and it is during this period that the "grandiose self" and the "idealized parental image" emerge. These are *developmental phenomena,* not to be confused with *defensive reactions,* and they appear later on in the transference of borderline and narcissistic personalities due to the conflicts and unresolved difficulties of this 6-to-10-month era.

These concepts of early infancy are difficult to accept. I believe that the infant "*feels good" about accomplishment,* even at a very early age, and *even if no one responds.* When the infant is by himself, his learning is a pleasure for him. When he accomplishes something, he coos, he is excited. He also responds to people. He smiles at them, he "talks" to them (see Trevarthan. 1074). The infant under favorable conditions experiences "pleasure" both alone with his own accomplishments and with others in an interpersonal encounter so that Kohut's idea of a "self" during this early period with respect to pleasure and unpleasure is completely conceivable. Perhaps this should not be called a "grandiose self"; nor is the pleasurable experience completely dependent upon the mother's responses. Grandiosity is a much later phenomenon that has defensive connotations and is related to more advanced social constructs than those of the infant. The grandiosity is actually associated with fantasies. It would seem that fantasies of power, strength, and

beauty indicate a contest, and there does seem to be a power struggle in the family of the individual who becomes borderline, a struggle that is sadomasochistic in nature. The experiments by Asch (1952) and Milgram (1973) are relevant to this issue. They indicate a *trait of susceptibility to suggestions* or commands that we find is a characteristic of the borderline stemming from the experience of giving in to rigid, demanding, and controlling parents who urge acting out. The demands are sometimes acceded to through passive behavior and at other times resisted by way of aggressive acts. However, the aggressive acts are sometimes stimulated by the parents. Unraveling the dynamics of the sadomasochistic problem with the paranoid feelings and anger related to it is a tedious and long drawn-out procedure. The first two sessions with James Weber reported in Chapter 11 are a beginning stage in an attempt to work through this problem.

Freud spoke of "giving in to the other" as a trait in homosexuality. It is also a trait of the borderline. There seems to be a need to act out homosexuality in a sadomasochistic way when some borderline patients feel belittled and wish to get revenge. This trend can be expressed as a fear of acting out in a homosexual episode for those patients who have never had homosexual experiences. The trait of susceptibility seemed apparent in my patient Harriet Hamburger, who felt she had to give in to the demands of female coworkers. She had the same feeling about males, but at work she was afraid of males and kept a distance. She would feel suspicious of both males

and females, but she could form friendships with women and could feel close.

Harriet had a fear of homosexual acting out, and for three years she spoke frequently of her homosexual trend, although she never did have homosexual experiences. Her fears were related to transference feelings, which she was not able to work through until many years later. Her mother who ruled the family through hysteria and other controlling mechanisms was very competitive with Harriet, always telling how she was sought after by men. Harriet was never able to form relationships with boys in her teens. The mother also had a repetitive fantasy of her husband being unfaithful to her, but Harriet felt the father never did have affairs and was completely under the mother's thumb. The mother's sexual fantasies were "purely in her own head." The father was a kind of "dandy" and did smile at women, but the mother's fantasies and accusations were groundless. In Harriet's case any references to any possible hostility to the analyst was complete unacceptable to her, but her identification with the analyst's work was evident in her behavior. She became interested in writing for a paper that popularized psychiatric concepts, which she did for several years. This acting out meant that the patient had ambivalence toward the analyst that could not be worked through but was acted out. "I am better than you are; I am smarter than you; I can interpret better than you; I have contempt for you." On the other hand, she admired the analyst, but she was obsequious for the most part.

Freud would call this transference problem an aspect of the oedipal problem, the analyst representing the mother with whom the patient competes. Current borderline theorists might see this situation with the patient as an aspect of the "split ego," and Kernberg in this kind of analytic relationship might advocate confronting the patient with her "polarity" in accepting and rejecting the analyst. Kohut might see this maneuver as an attempt by the patient to obtain appropriate mirroring from the analyst. I saw this as competition, a fear of "giving in" to the competitor, a fear that was acted out (a pantomimic transference) rather than talked out. When I attempted to discuss the problem, I met strong resistance and deep detachment. Therefore, I would wait until she herself brought up the matter, even if it had to be a period of years. The good feelings I took as appeasement (masochism). The competitive feelings were, in fact, sadistic in nature, with strong defensive resistance to interpretation. Accepting interpretation would be a "giving in," a manifestation of her trait of susceptibility, a masochistic move which she did not want to admit that she was fighting. Her behavior was in a sense counterphobic, and yet she was highly competitive. Harriet had no conscious wish to "merge." She had contemptuous feelings toward the analyst, but unconsciously she wanted to be near the analyst. She wanted to be special, to be smarter than other patients. She would look upon each interpretation with wonder, saying that the analyst was "so astute," "so sensitive." Such attitudes require special treatment techniques.

In the next chapter we shall discuss some research papers and some of the writings on special problems related to the borderline syndrome.

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Notes

10 Freud had a theory that a patient could have two attitudes existing side by side without influencing each other. This was described in a case of fetishism and in the amnesias.

11 Some theorists may question the concept of an ego-ideal as inconsistent with Kernberg's idea that the borderline patient has no true identification system on the "higher level." Others see no problem, they believe the identification process, which is seen as a pivotal factor in ego and superego development, can be acquired in the therapeutic process. Kernberg accepts introjection as a form of identification. Since in the psychoanalytic frame of reference identification is a developmental necessity, the patient after working through his oral and anal stages will automatically identify with the analyst, and the oedipal

dynamics will begin to unfold. The analysis itself is a developmental process. In view of this idea that the borderline patient lacks a “higher level” identification system, Kernberg (1975, p. 89) proposes that transferences in the patient do not always reflect experiences with parents. In light of the self-object concept the borderline has no “observing ego” and the “lower level” borderline have no guilt (Kernberg, 1975, pp. 79-80, 19 respectively). These are severely masochistic characters.