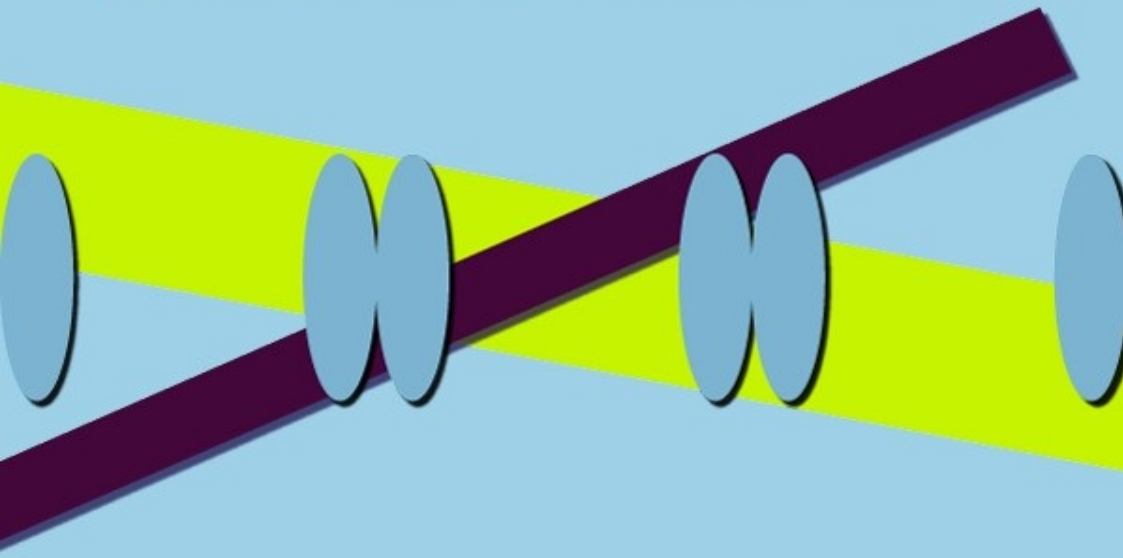
COMMENTS ON CURRENT THEORIES



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Comments on Current Theories

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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.