EARLY PSYCHOANALYTIC CONCEPTS CONCERNING BORDERLINE CONDITIONS

ARLENE ROBBINS WOLBERG

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Arlene Robbins Wolberg

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Between 1937 and 1954 , beginning with Adolph Stern, very few papers were written on the borderline patient (about 25 were published including my own first paper in 1952). One of the major findings relating to the borderline during the late 1930s came from the psychologists who worked in the testing field, particularly Rorschach and others who employed projective testing. They discovered that on structured material the borderline did very well, but with the unstructured material the patient showed anxiety and pathological responses.

Adolph Stern

Stern read a paper before the New York Psychoanalytic Society in the spring of 1937 expressing ideas that were published in 1938 in a treatise entitled “Psychoanalytic Investigation of a Therapy in the Borderline Neuroses.” The paper contained descriptions of many essential features of the borderline group of patients as well as interesting information concerning their families. Stern stated that regular psychoanalytic procedures were not effective with “neurotic characters” who made up a large number of

borderline patients. While he had “handled thoroughly enough the object libidinal phenomena” when treating these patients, they, “nevertheless, remained sick.” He listed a number of symptoms typical of borderlines (though not all specifically confined to borderlines):

1. A narcissistic neurosis

2. Psychic bleeding

3. Inordinate hypersensitivity

4. Psychic and body rigidity

5. Rigid personality

6. Negative therapeutic reactions

7. Seemingly rooted feelings of inferiority

8. Somatic insecurity or anxiety

9. The use of projective mechanisms

10. Difficulties in reality testing, particularly in personal relationships

We shall consider each of the symptoms, then examine Stern’s thoughts on the effect of the home environment on the borderline, and conclude our examination of Stern with a discussion of his approach to the treatment of the borderline.

Narcissism In the history of borderline patients Stern found that adverse factors were present in early childhood affecting narcissistic development. In at least 75 percent of the group Stern treated, the mothers were neurotic and some had had psychotic episodes. Practically all of these mothers were deficient in demonstrating affection, many being over-solicitous and overconscientious. Some were meticulous about food habits and behavior but lacked a wholesome capacity for spontaneous affection. In the families there were many quarrels and bursts of temper between the parents, also anger directed at children. (I would judge this to be anger, displaced from both marital partners based on their identifications with their own parents—the projective identification defense. I Some parents had been divorced before the patient was 7 years of age; thus a “separation experience” for the child took place. All of the children in Stern’s group had remained with the mother, “not one of whom was an adequate mother from the point of view of affection.” Actual cruelty, neglect, and brutality by the parents over a period of many years were common factors. (Today we call such children abused or battered children.) In reality, neglect can more precisely be defined as rejection. Consequently, these patients suffered “affect hunger” (Levy, 1932) or what Stern called “narcissistic malnutrition.” Defects in narcissistic development seemed to be the cause of the symptoms and personality problems in this group of neurotic patients. The self-esteem was low. Prevalent were (1) insecurity, (2) lack of adequate affective relationships, and

(3) disturbances between father and mother. The research of Grinker seems to bear out the validity of these three factors in the lives of borderline patients (Wolberg, A., 1973, pp. 149-150).

Psychic Bleeding Instead of a resilient reaction to a painful or traumatic experience, the patient, as described by Stern, “went down in a heap,” appeared to be immobile, in a deathlike collapse instead of a rebound. In other words, the reaction was a sort of “playing possum” (a phrase used also by Laing [1970]), showing paralysis rather than fight or flight. This is obviously a flight reaction in the form of a masochistic maneuver with hysterical features. It is also a hostile controlling maneuver in the adult to make others feel guilty and do for the patient what he should do for himself. On another level it is a defense to protect the “object” from the patient’s aggression.

Inordinate Hypersensitivity Excessive hypersensitivity seemed to serve as an exquisite receptive apparatus or instrument *to detect danger.* The patients were constantly being insulted by trilling remarks and occasionally developed mildly paranoid ideas. [Can it be that their parents displayed paranoid traits not only in relation to their controlling, monitoring tendencies, but also in their denial of their deceitfulness, which is a part of their defensive systems (a source of the “double bind?”). The parents “remake reality,” which is a defense—in simple language, they lie as an aspect of

defense. The patient, as a consequence, is characteristically on guard with others expecting a similar kind of behavior as evidenced by my session with George Frank Quinn (see Chapter 7).]

Psychic Rigidity Stern connected psychic rigidity with insecurity. It was “almost of a reflex nature” like the rigid abdomen or, in the extreme, like the catatonic with his shifting, watching, alert eyes and the rigid posture of his body. Such rigidity begins in the early years, before age 4 or 5. This kind of “alertness” is perhaps the same trait that Rosenfeld (1965) talks of in his concept of the superego quality that is “omnipotent,” “omniscient,” and “omnipresent.” It is an indication that the parents, over the years, were excessively controlling, watching every movement of the child, monitoring, so that he would not step out of the identification mold they proclaimed for him. This “superego quality” in the patient is learned from the parents’ rigid, punitive, and cruel restraining watchfulness. The phenomenon is depicted in the man and woman drawings of my patients Harold Hemple and Harriet Hamburger (see pp. 238-249). At the time that Harold sought therapy he was 32 years of age, single, and employed in a very good job with an adequate salary. He had a kind of paranoid feeling, i.e., a distrust of the motives of others. This originated in his experience with parents who also had this attitude and who denied or lied about what they were doing to the patient. In projection, this wariness was a transference manifestation toward others.

In the case of borderlines, and schizophrenics as well, the patients have been deprived of adequate peer relationships by the neurotic and/or psychotic parents *who have bound them in a family interlocking defensive relationship.* Fear of others together with a lack of experience in getting along with people and of feeling accepted makes the relationship with peers a stressful experience. This becomes a source of intense anxiety at school or at work. It is also a factor in the sexual realm and in treatment. (Harold had dreams and fantasies of cringing before others. He would not allow himself to become aware of his grandiose feelings and his "wariness" until the fourth year of his seven-year analysis.)

The "watching" and "wariness" can also be related to the sexual problem that develops because the parents have not accepted their own sex roles —thus they experience anxiety when their children act sexually and normally toward either parents or peers. In addition, the parents themselves use their children in secretive ways to satisfy their own sex needs through perverse modes. These controlling, punitive, and abusive parents frequently express their perverse trends by staring at parts of the child's body, developing in the child obsessive patterns concerning certain organs (Wolberg, A., 1973, p. 42).

The road to good relationships with peers is blocked by these many problems, and there is the constant guarded alertness to see what the other

will do. This excessive attentiveness began in the family, the child trying to decide what the parent wanted or would do next. “Watching” is also based on a fear of what will happen. In the session it is as if the patient is always wondering, “Will the other pierce my defensive armor?” The patient realizes his inadequacies in his relationships with others and is often rejected for them. He sometimes is ridiculed by other children for his rigidities, his fears and his need to control, his sensitivity, and his apparent frailty.

Emotional closeness is a threat to the borderline patient’s parents, so that the individual learns to use hostility and withdrawal to give himself distance in his relationships with his parents, and thus with others. In spite of all that has gone on, however, I do not find that the borderline patient stays away from the opposite sex. Rather he relates to the opposite sex in a sadomasochistic way.

Negative Therapeutic Reaction Readily aroused anger, discouragement, and anxiousness, said Stern, are responses by the patient to any interpretation deemed injurious to self-esteem. Interpretive activities are seen by the patient as evidence of lack of love or appreciation on the part of the analyst. One reason that I suggest *generalization* in discussing problems and the use of the *projective therapeutic interpretation* in the beginning of treatment (in fact at any time where denial and other defenses are in use) is that at these points direct interpretation will fall on deaf ears, and the

therapist will stir up defensive maneuvers in the patient. A negative therapeutic reaction (NTR) often means that a premature interpretation has been made and the patient will “get even” by trying to make the therapist feel guilty. This is an aspect of the complicated defense of projective identification and the sadomasochism that is inherent in the defense, which includes revenge attitudes. The masochistic aspect of denying the reality of the confrontation is a way of putting off the therapist. It is as if the patient is saying, “Look you have injured me! I cannot tolerate this closeness! ” It does no good to point out this defense directly at first, since this only increases the patient’s paranoid mechanisms and projective maneuvers to make the therapist feel cruel and guilty and thus to desist.

Stern’s “psychic bleeding” is a masochistic trait of this same nature. It appears often in the treatment situation and must be interpreted at first projectively, using “others” to point out the maneuver. When direct interpretation is made the first time, it should be approached in general as follows: “When I talked of the possibility of the meaning of your behavior, this stirred up anxiety in you and your reaction was to feel hurt.” The strategy to make the therapist feel guilty—a devise often used with the patient by his parents—must be discussed at a later time. Interpretations must be done step by step or piece by piece, so to speak, eventually fitting all the parts together and always referring to the patient’s anxiety as the stimulus for his defensive behavior. This piecemeal technique is used in the face of denial, taking into

consideration what the patient is willing to tolerate at any given point in time. We judge this by listening to his productions, asking for his dreams, and focusing on the area of least anxiety. The negative therapeutic reaction can be a pervasive masochistic reaction with great fears on the part of the patient that his defensive armor will be destroyed, and a “flare-up” of the kind where symptoms appear usually means that the patient cannot tolerate the anxiety. The patient also can have the opposite kind of reaction, using a counterphobic attack against the therapist employing verbal abuse or teasing.

There have been many suggestions in the literature as to what causes the negative therapeutic reaction (NTR), and each may be correct in any given case. Already noted have been the general masochistic stance in all cases and the feelings of guilt. Revenge feelings (sadism) account for some of these reactions: “I will never let you help me even if I frustrate you forever.” This is the help seeker who refuses to let you help. His reaction, of course, is masochistic at the same time that it is sadistic. Envy has also been suggested as a motif for revenge. In my opinion it is the sadism of the parents that creates the envy and the revenge feelings; then in denial these are projected or displaced. One finds that the negative therapeutic reaction, in the early stages of treatment, is usually related to the passive-aggressive character pattern of the patient—the need to feel no pleasure from attainment, even in treatment. This negative or antagonistic feeling is related to “oppositionalism,” and to the patient’s perverse feelings. It creates a kind of

sexualizing at times in the therapeutic relationship, a type of masochism, a function of an excited or somewhat elated mood, a defense or counteraction to the depression. The borderline patient has mood swings (not, of course, such severe swings as manifested by the manic depressive) related to what I have described as a twelve-step cycle (Wolberg, A., 1952, pp. 696-699). In treatment a depiction of these various facets of the sadomasochistic cycle should take place before the mention of envy, jealousy, and sadistic feelings. Such delineation helps to reduce the negative therapeutic reactions. The envy often is a function of the passivity that the patient feels and his poignant wish to be more assertive as he sees others being assertive (see Wolberg, A., 1973, the session with George Frank Quinn—named George Adler in my first book —pp. 216-219, and the session with Elizabeth, pp. 246-2511.

Freud (1913) referred to the patient's inability to enjoy his attainments (or to deny that they exist) as a pre-obsessional factor and he connected this with sadism (Wolberg, A., 1973, p. 95, note 15). There is often a negative therapeutic reaction when the patient denies pleasures in attainment. I believe that this is a characteristic also of perverse sexual feelings which are an aspect of the revenge motif. My patient Elizabeth had this problem (Wolberg, A., 1973, p. 244). She would often say she could not *feel* during the sex act, but mostly she would begin to feel and then lose the feeling (turn off); finally she would burst into tears. On one occasion I was able to elicit from her a fantasy she remembered while having intercourse, of her father

taunting her.

Feelings of Inferiority Stern described feelings of inferiority as pervasive feelings. Even when borderline patients are highly successful, they insist they are inferior, almost in a delusional sense. Such feelings of inferiority are used to overcome anxiety whenever action or thinking is required that might demand what could be called “adequate functioning.” In the therapeutic session the feelings of inferiority serve the patient against being active, and thus he hopes to bring out the parental role in the therapist. (This is one way that transference is expressed in the beginning of treatment.)

“These mechanisms, even when analyzed, are so tenacious that they have little effect on the patient who continues to remain sick.” It is my impression that in such a case the “feelings of inferiority” have not been considered as acts of masochism and appeasement, covering anger, rage, contempt, sadism and the fear of ridicule. If these feelings are recognized as masochistic defensive maneuvers, then one has a different attitude toward this behavior than if one thinks of the behavior as “ego weakness,” “lacunae,” or “defects.” When the patient is saying “I am inferior” or he is acting inadequate, he is really telling the therapist that the therapist by contrast is perfect and that he, the patient, is nothing.

The expression of inferiority, verbally or nonverbally, has been

mistaken as the patient's inability to perceive the situation as it really is; actually, it is the acting out of a transference maneuver, or what I call the *pantomimic transference* (PT), a sadomasochistic act. The patient is dimly aware of his behavior, but he represses the idea that he is acting toward the therapist as he had to act with his parent or as the parent acted with him.

For such patients interpretation must be made over and over again since inferiority feelings are deeply ingrained. The therapist must use a special type of interpretation, if an adequate point is to be made with the patient. The therapist needs to point out that the patient's self-denigration is the acting out of a masochistic role for purposes of appeasement. While the patient is aware of *what* he is doing, he blocks the reason *why* he assumes this role. The *why* is left for the future, and we, as the therapists, ask the patient to observe the pattern in his everyday life, suggesting that he take note of the situations that precede his acting out this role, much as we might ask a patient who has a headache to give attention to the kind of situations that precede the onset of symptoms. Some patients will not win at a game, even though they could at times do so. Some patients will act inept, for example, at particular tasks they may have to do, such as anything mechanical, anything creative, anything mathematical (see the description of the behavior of Gertrude Belan in Wolberg, A., 1973, pp. 78-79).

Masochism It is usually very clear, said Stern, how masochism fits in the

borderline personality as a defensive or protective phenomenon. Masochism is present and obvious. Self-pity, self-commiseration, and the presentation of being a long-suffering, helpless, and injured one (a kind of wound-licking) are regularly seen. There is no doubt that these patients have suffered much, and among their symptoms we see mild depressions. They hurt themselves in all effective relationships—business, professional, social and others. But, said Stern, it seems futile to say that masochism in the borderline is entirely defensive or protective.

It is necessary to have a clear concept of the myriad forms of sadomasochism as defensive behavior if we are to treat borderline patients successfully. Many of Stern's stated characteristics of borderline can be seen as sadomasochistic. Self-defeat is a form of sadomasochism, for it is related to revenge behavior, anger, oppositionalism, and the NTR which can come from guilt that has not been sufficiently explored in the sessions. Masochism continues as a factor in the therapy with the borderline patient almost throughout the therapeutic process—masochism associated with anger, revenge feelings, fear, and guilt as illustrated in the session with George Frank Quinn (see Chapter 7). Anger turned on the self is often projected in a subterfuge as if the other had done the projecting. This is typical of the defense of projective identification except that we must realize that the anger is not a "primary instinctual anger" that occurs without provocation as Melanie Klein proposed: it is a *reactive anger* that began in relations with

parents and accrued as time went on, eventually becoming associated with revenge fantasies and techniques. When aroused, the patient's projection and the displacement to a third person is a transference reaction, a way of handling intense anger at the "other," and reflects the strong impulse to demean the "other" as a representation of the original parental object.

Many therapists regard this kind of negative therapeutic reaction as a manifestation of an inability to integrate the "good" and "bad" of the object. The inability to integrate good and bad, they explain, is a characteristic of two factors: (1) a constitutional defect of excessive aggression which creates (2) a defect in the defensive system preventing the individual's progression from "splitting" to the next stage of defense—repression. Actually, rage that takes the form of feelings of revenge, when confrontation occurs, is accompanied by the patient's transferential wariness of the therapist or others whom the patient fears are bent upon breaking up his defenses, a fear that is groundless if the therapist is handling himself in an appropriate manner. (The question of fantasies and an understanding of their importance and their dynamics in relation to this problem is discussed on pp. 126-127.)

Self-demeaning is another aspect of sadomasochism. It is a defense against the wish to violate or hurt the "other," often physically (see Wolberg, A., 1973, pp. 210-211, 216-219). When the patient "goes down in a heap" after an interpretation and asks for directions, acts helpless, says he cannot figure

out what to do and the like, he is employing the masochistic defenses used with parents. Therefore, they are transferential with the therapist. The therapist must respond, not by thinking that the patient is "defective," but by recognizing that he is acting in a self-demeaning or masochistic way, using the analyst as an idealized figure. Such behavior is an example of *pantomimic transference* (PT). The PT is a sadomasochistic act—an attempt to hide the sadism of controlling others, making them "help" and then frustrating them by not letting them succeed in the helping process. It is a mechanism used in the negative therapeutic reaction as well as an expression of guilt over possible success, an undoing, so to speak.

In response to the patient's self-demeaning behavior and helplessness, the therapist must interpret in language such as the following: "I know that you have behaved this way before and you are now, for some reason, presenting yourself to me as someone devoid of reasoning powers. I guess something or someone must have made you very angry or very anxious, or both. Perhaps we should examine what happened in more detail so that we can understand your anxiety." The therapist should not ask why or query "What does your part in this exchange mean?" or comment "You are doing it again."

This kind of patient reaction is also related to what Kohut might call the "idealizing transference" (in my terms, pantomimic transference), not

verbalized but acted out nonverbally; in other words, “I am weak; you are great. Tell me, all-wise seer, what to do.” This behavior is often mistakenly taken to be a manifestation of dependency rather than of the sadomasochism that it actually is. Kohut (1971) views it in an entirely different way—as an indication that the patient is trying to make up a developmental deficit. For Kohut, the patient is attempting to get from the therapist what he could not get from the mother so that he may experience self-esteem. He wants praise and he is idealizing the parent-therapist as a step in developing an ego ideal and an identification with an adequate object. In my opinion such behavior is an act of masochism and the opposite of grandiosity, which the patient often feels. When it is translated, it means, “You, the therapist, are a worm! I have you! ” Historically, the parent has indeed told the patient what to do and has behaved in the role of “all-wise seer” and the all-encompassing authority, acting as if the patient were “a nothing.” Particularly when the child violated the defenses of the parent, he was made to feel guilty for not keeping to the neurotic code and the commitment to the identification that is so important to the parent in relieving his own anxiety and his fear of losing control of the child and thus of his own defense. What the parent has communicated to the child is that the child must perform a sadomasochistic and self-destructive role to relieve the anxiety of the parent. The child’s (or patient’s) grandiosity is a counterphobic measure, a way of dealing with his fear of destruction, a defense against fear of the aggressor—the parent.

Is the patient's masochistic reaction due to fear, based on an original fear of abandonment, as Masterson (1976) and others have suggested? Or is it a fear of *annihilation* based on the fears of parental aggression and the humiliation of being used by the parents in the interests of their own defenses? The patient's fears are actually multidetermined. They are, for example, the reactions (as a child) to the parents' fears of having to face their own aggression and their sadistic feelings toward their children. They are the parents' fears of facing the reason for their depressions, a fear of recognizing guilt, a fear of facing up to the lies and deceits needed to maintain the projective defenses, fears of expressing autonomous and constructive behavior, sexual fears, a fear of challenging the ideas of their own parents and ridding themselves of their identifications with their parents, fears of losing controls, fears of losing their children as projective objects, the fear of having to acknowledge their overt cruelties toward their children. In turn, their children who become borderline have fears of exposing their parents and themselves by various confrontations.

The borderline's original fears of the parents began between the ages of 3 and 5 when the child's defenses were, in part, to project from the family onto animals in fantasy. Other symptoms appear as well in what has been called the "infantile neurosis" through manifestations such as panic attacks, tics, rigidities or obsessional patterns (more precisely, repetitive patterns to control the fears and change the meaning of the events in the environment),

inhibitions, intestinal disturbances, temper tantrums, fears of the dark, fantasies of being hurt, and so on. Freud tended to categorize such symptoms as "constitutional defects" that prevented the child from reacting rationally to the ordinary stress situations that occur as a consequence of normal maturation as a child plows through the "psychosexual phases of development." It is much more probable that these manifestations are due to (1) fears of the parents' aggressive behavior as parents cope with their own anxieties and (2) fears of the counteraggression felt by the child himself.

Masochism and sadism, its concomitant, are still much misunderstood phenomena in treatment, and masochism in some forms is not obvious as Stern thought. In the borderline patient "fear of abandonment" is considered a "regressive" fear and is attributed to a "separation anxiety" such as a child might have when the mother is out of the room. This fear has sometimes been called a masochistic symptom. Melanie Klein suggested that such fear is due to the child's own aggression, which he somehow recognizes in the period (age 3 to 12 months) when he is defending against "innate oral aggression." If one explores the abandonment fear, however, one finds that the patient will "feel lonely" without another, "cannot tolerate to be alone," will experience a "rejected" or a "poor me" feeling, or will be "jealous of others who have someone." Some patients express "fear of what they will do if alone." Actually, they fear facing their own aggressive feelings, which they can discharge if they are with someone, but when alone they are deprived of the projective

vehicle. In that case they sometimes fear they may turn on themselves in a suicidal fit. Group therapy has been considered advisable as a vehicle for the borderline patient so that he can dispel some of his anger by projecting it to several individuals. It is my thought that also in the group the sadistic concomitant of the masochism can be interpreted as a defense against the self-demeaning pattern.

For many years most psychoanalysts refused to consider group therapy a valid instrument for helping patients.[4] It, however, became a technique with the more difficult patients out of the desperation of therapists who were willing to try any method that might yield results. In psychoanalytic practice a family group process was considered advisable in the treatment of young children in the light of Freud's developmental theory. The "preoedipal phase" of development was treated via the mother-child relationship while the later Oedipal period was handled within the confines of the group of three, that is, mother, father, and child. Interaction dynamics were neglected for adults in psychoanalytic circles, however with some exceptions (Wolberg, A., 1977). Jackson was a pioneer in this area.

"Abandonment" fear is considered to be an oedipal concept, thus a group concept. I believe it is a fear of losing the object upon whom rage can be displaced. It is the fear of losing the substitute for the parent before the patient has worked out counteraggression and hatred for the parent to a

tolerable degree. Interpersonal relationships are contaminated by this fear. Abandonment is a fear, however, that is much more complicated than the fear that an infant feels when the mother goes out of the room. It is a fear that belongs to a later phase of life than the so-called “narcissistic” stage. The basic fear is of *annihilation* in the face of parental aggression, but this fear comes after the child has accepted an identification with the aggressor and thus has begun a sadomasochistic mode of life. The pattern can begin as early as age 3 under extreme pressure from parental figures, as was evident in the case of Roxanne Felumero (Wolberg, A., 1973, p. 12). Roxanne did not accept or “internalize” the identification although she lied (distorted reality) before a judge as her mother told her to do. She had not yet, however, at the age of 3 accepted the identification, internalized it, and repressed the ideas related to the abuse she was receiving, nor had she yet idealized her mother. She was fighting against this process. Just when such identifications are internalized and the repressions and denials do set in, I do not know. The periods probably differ with different situations and children. The time period is, I believe, much later than is currently supposed. This does not mean that repression or other defenses do not occur earlier, but we are speaking of the identifications induced by the trauma of parental behavior when the parents are sadistic and brutalizing.

Abandonment fears come only to children and their parents who have been punished in childhood by sadistic authorities threatening to leave or to

force the child to leave if the child steps out of the neurotic sadomasochistic role. There are nonverbal indications of "leaving" even when the parent is present—for example, withdrawing, not speaking for days, looking at a person and using facial expressions of disgust, and the like. This is PT behavior of an inverted nature. Out of anxiety, the individual takes the role of the feared person and uses the other as himself, heaping scorn, sarcasm, contempt, and aggression upon the other. It is one of the mechanisms in *projective identification* (PI). In my opinion the borderline's fears are more of *punishment* and *annihilation* than abandonment in the beginning, due to the punishments they actually do receive when they temporarily give up the identification roles projected onto them by the parents. Later the fears are mixed with fears of anger over the frustration the child felt in succumbing to the parents' neurotic needs, and still later the frustrations are associated with revenge feelings—and perhaps with abandonment as a punishment.

Borderline patients are angry and hostile, but I have never worked with a borderline who did not have a picture of himself or herself as a beaten, passive, helpless depressed person from early childhood on. In the formative years the patient was in the clutches of punitive and sadistic parents, but at the same time that the parents are described as cruel, abandoning, threatening, neglecting, detached, and so forth, they are idealized and defended. Usually, one parent is felt to be less punitive than the other, the less punitive one being considered to be under the thumb of the more punitive.[5]

What is denied is that *the patient has identified with these sadistic characteristics of the parents and is now, in this sadistic respect, like the parents.* Even though he describes the parents as sadistic and often alludes to his own sadism, denial and negation are especially strong when the patient is confronted with his own statements (see the case of Lisa in Wolberg, A., 1973, pp. 208-209). As the identifications solidify, not only does he defend against remembering the traumatic experiences that helped to create the identifications, but now he defends his own behavior that is a consequence of the identifications. In a session with the therapist, the information about the parents and the identification role is given in a disjointed and often dissociated form, which is an aspect of the denial mechanism.

With respect to the sadistic qualities of the parents, those parents whom I have known do indeed have sadistic characteristics. The patient is not projecting his own innate sadism onto the parents. They are sadistic. The patient acts out his transference responding to others as he did with his parents out of his neurotic necessity. Thus he projects not his raw aggression but his *reactive hostility* onto others. As a counterphobic measure he will act out the role of the parent with others. This is a PT maneuver in view of his identification with the aggressor (IA).

The borderline patient often hangs on to feelings of having been cheated in life by the parents, but he defends against revealing these thoughts. His

explosive reactive rage and revenge feelings against the important people for whom he wishes to feel love in spite of everything that has happened are cause for guilt. Many therapists do not recognize the more subtle forms of the borderline's guilt in relation to his masochism and sadism, and thus they often miss the opportunity to interpret this phenomenon. "Wound licking" for example is a way of trying to make the other person feel guilty. It is part of the projective identification defense, which is a sadomasochistic maneuver. It is a form of acting out (i.e., a PT experience) based on rage and guilt combined—rage at having been abused and neglected and guilt for the feelings that have been aroused in the patient as a result of life with the parents.

Somatic Insecurity or Anxiety The psychosomatic apparatus, asserts Stern, has been conditioned in the direction of tense and rigid preparation against ever present traumatic assaults. Chessick (1977, p. 220) has commented on the tendency of the borderline patient to develop psychosomatic symptoms, and he has suggested that therapists should always encourage the patients to be examined by a physician when such symptoms occur. This is important advice. It has been my observation that somatic symptoms do occur frequently in these patients. This is due to the anxiety and accompanying physical tenseness that the patients experience daily and even hourly, no matter how detached and withdrawn they may appear. The bodily tensions are great, and the organ systems (circulatory, gastrointestinal, and so on) are undoubtedly affected. Stern said that these

patients do not complain of anxiety. In fact, they do not seem to have anxiety as a constant symptom. They often present a stolid physical and mental equanimity and at times they do not seem to be disturbed by their situation. (Stern seems to speak here of the patient's pervasive detachment.)

An inordinately strong system of defenses has been established so that the therapist must be careful to undo as little of the defenses at a time as possible, since these patients are capable of releasing unpleasant and sometimes dangerous quantities of anxiety in the course of therapy. Clark (1919) too thought it unwise to "pierce the patient's armor," and I feel that such penetration must be done very gradually, using projective techniques in the process. In treatment the deep, underlying insecurity is revealed, said Stern. Insecurity (masochism!) seems always to have existed. Periods of security were evanescent rather than more solidly established through growth, maturity, and experience.

These individuals, stressed Stern, express an all-out reaction to events or no reaction, which is similar to Kernberg's concept of the "all-good" or "all-bad" self and object images. (These patients, I find, have intense anxiety, but their detachment and withdrawal tendencies help conceal this fact. It is true they do not always complain of anxiety per se; but they often speak of being tense, and they have many inhibitions due to fear. The patient looks and acts anxious, however. Stony detachment is more likely to be a symptom of

schizophrenia rather than of a borderline condition.) In childhood, Stern continued, these patients have been inordinately submissive and obedient through fear and need. *They cling to parents and substitutes in the desperate manner of the greatly endangered.* (Clark thought that in analysis we must help the patient "have a questioning and investigative attitude toward parental dictates rather than *cringing acceptance*.") Harlow (1962) has observed that the more rejected his baby monkeys were, the more they clung or, more precisely, the more they tried to wring from the mother what they needed in their development. This aspect of human behavior in infancy has erroneously been taken to mean that the child is "symbolically tied to the mother," but in my opinion such behavior is *self-actualizing behavior, an assertive attempt to gain what is needed from one or the other* of the parents. Usually, however, it is doomed to failure due to the emotional problems of the parents. Children do try to get what they need, and even try to protect themselves from the aggression of the parents. They complain when they do not get what they need, but they are often made to feel guilty for their complaints. The mother of Harriet Hamburger, one of my patients, said that as a child Harriet "urinated through her eyes," meaning that she cried and whimpered a lot. This was meant to say to Harriet "Look what I had to suffer from you" to cover the mother's guilt in not being able to give Harriet what she needed. The concept of symbiosis, which includes the idea that the patient considers himself one with the mother rather than a "separate person," is

used constantly to explain these different kinds of masochistic behavior in the borderline.

The chronic anxiety and insecurity of the patient, I believe, comes from the basic rejection received in relations with parents. The patient cannot feel wanted, for he is used and demeaned. Finally, in turn, he does the same with others. It is this kind of interpersonal experience that evokes the sadomasochistic pattern. The anxiety is often somatized, taking the form of worry about the body—a worry that occasionally borders on delusional fear. The identification with the aggressor (the parent) is partially converted to self-contempt in the face of the tension and anxiety the patient feels as he copes with these conflicts. Some of these conflicts are related to the perverse use of the child's body by the parents, that is, their manifest concern about the child's body parts (Levy, 1932). A parent's obsessive interest in body parts (his own or his child's, or both) may be a manifestation of the sexual perversity of the parent and the source of the child's preoccupation with himself. This is a more plausible explanation of hypochondriasis than speculation that oral aggression in an early narcissistic stage has gone awry. The "clinging" Stern spoke of is better understood if we think of Harlow's battered monkeys (1962, 1975) and the fact that the infant tries to make the unwilling parent or a substitute object give what he needs. (The parents are "unwilling" due to the fact that they themselves were rejected and denied what they needed in the way of protection and warmth in family

relationships.) Later the child's rational demand is fused with the sadomasochism that arises not from some instinct that automatically makes its appearance in the "oral" or "anal" period along with envy and other esoteric feelings assigned by certain theorists to the first few months of life, but from sadomasochistic patterns that develop gradually through experience with "battering," brutalizing, and cruel parents. There is much "mental battering" due to the parental aggression in the form of repetitive parental use of their children, in defense, as projective objects (a conditioning process, over time) entailing displacement of those aspects of their identifications with their own parents that they deny in themselves (Wolberg, A., 1968, pp. 108-109; 1973, pp. 2-11, 12-13, 25, 55 [note 7], 92-93, 102-103, 148-149; 1977).

Stern noted that in early childhood in the relationship with parents there was "cruelty, neglect and brutalization by the parents." He did not mention how this can be corrected with sexual feeling. The perverse behavior using the child as object is a consequence of the parents' sexual problem. "Love" for these children is sadomasochistic in nature since sexual feelings are bound to arise in the general course of events and some disposition of these feelings must be made.[6] Obsessive talk is one way that the parent has of "letting off steam" or of handling anxiety. This "talk" centers around the areas of anxiety, sometimes sexual, sometimes nonsexual (see Wolberg, A., 1968).

There is enough favorable feeling in the relationships with parents, however, so that borderline patients do not become isolated as is the case with many battered children.[7]

The Use of Projective Mechanisms Stern thought that the common use of projective mechanisms is one of the phenomena that links borderlines with psychotics. The “immature narcissistically needy person” protects himself from what he considers a hostile environment through defensive measures, such as the development of a rigid personality, introversion, psychic and physical withdrawal, a mild delusional system.

I feel that we must picture this “immature narcissistically needy person” as an individual who was deprived and frustrated, over time, and “used” by his parents as a projective object in the course of their defensive aims. This individual was forced to identify with those aspects of the parents’ identifications with their own parents that the parents needed most to deny. My conception differs from the view that the individual is a defective whose ego functions are “missing” due to an early “fixation” in the period of 10 to 18 months. Our “needy person,” the borderline patient, develops a revenge feeling that he acts out with others, and with the therapist, hoping to succeed in using these objects to satisfy his reactive hostility against which his projective mechanisms are partly used. He does have ambivalent feelings toward the therapist; he has good feelings that show up occasionally, but in

general he tries to keep them hidden. These feelings are to be distinguished from the appeasing positive transference feelings that are masochistic in nature and that take so long to unravel and to analyze. The ambivalence is what creates the obsessiveness of the borderline patient—the “yes-but” symptom related to the patient’s reticence about making clear-cut decisions.

Difficulties in Reality Testing Borderline patients, Stern stated, accept a fantasied role of the therapist as god-magician *as if it were a reality.* The ungratified and ungratifiable narcissistic needs are responsible for the demand that the therapist be “the greatest.” This psychic and physical image is of utmost importance to the patient. Here we recognize the masochistic role the patient assigns to himself and the grandiose role or, to be more precise, the sadistic or controlling role, assigned to the therapist, a transference reaction. The patient does reverse these roles in transference, however, shifting from one to the other, and this becomes disconcerting for the therapist. The idea of a grandiose person in the therapist, I have found, is a projection in one sense; in another sense, it is a masochistic wish (sometimes called a passive-dependent wish) that the therapist be not just the helper but the "rescuer.” Underneath this wish, which is masochistic and passive in nature, is a hostile and paranoid-like reaction or defense. The patient feels that he should be able to “act out” the wish to relieve his neurotic anxieties, including his perverse wishes. Others, including the therapist, are assigned the role of undoing the self-destructive mess that his acting out of self-

contempt has entailed. There is hatred and revenge attached to this wish. The patient feels that he has been cheated by the world, and the world, in the person of individuals whom he can manipulate, must pay for his misfortune—pay, and pay, and pay. The patient has been manipulative from childhood, once he understood that he was not getting from his parents what he needed. This was a way of survival, and it becomes one of the most difficult transference reactions to analyze. Reality testing is intact, I believe, but in periods of intense anxiety defenses against reality are used.

Home Atmosphere The mother holds the key to the home environment, stressed Stern. Conceiving the world as dangerous, she imparts this to the child: "The apprehension is in later life a fertile source of so-called unmotivated anxiety." Stern contended that although the father's influence is important, it does not play the chief role until a later date. Stern saw the mother as the dominant figure in the early life of the child. It was she who set the atmosphere in which the child must learn to survive. He saw the mothers of borderlines as neglectful, beastilizing, self-oriented, and unable to perform a mothering role.

In the homes of his patients Stern observed that the parents were non-protective, dehumanizing, laissez-faire, and often overtly cruel. His patients came from upper-middle-class homes; thus there was no poverty to "distract" the parents. It was the emotional tone in the interpersonal relationships

between family members that was of a sadomasochistic nature. Occasionally there was physical battering. In Stern's opinion the mothers could not or would not take an adequate parental role. It was obvious that there was much discord between the parents, for a large number of the parents from his particular group of patients were divorced.

My observation is that *parents who have a disturbed, tumultuous home keep the child from forming adequate relations with peers because of their paranoid feelings and their need to hold on to and use the children as projective objects.* This is true of *both parents* in the case of the borderline patient. These parents often have a fear of strangers and of people invading the privacy of their sadomasochistic defensive system. The problems of the parents frustrate the child in finding companions and keep him in the sadomasochistic bind. "Clinging" is one response to this situation, but I believe that anger and rage come first. *The "clinging" is first a repetitive asking for what the child needs. Later appeasement is part of the defense against the anger and rage.* It is also a new way of "asking." In some instances, the neglect and the beastialization of the child by the parents has made the child act in ways that are obnoxious to people around him. Such patterns discourage forming relationships with "adequate" companions. These same patterns also often militate against therapy since many therapists refuse to treat these patients.

Treatment Stern wrote that in working with borderline patients "supportive" measures are called for. The relationship is as one to a "corporeal magician." (Kohut would call this the mirror transference attributing it to an unrequited early developmental phase at which the individual is now fixated.) The patients do not admit that there is something strange and odd in this attitude, said Stern. When the godlike fantasy is disturbed, the patient develops intense anxiety. "One can easily picture the anxiety, the depression and defensive anger, when the naively accepted love-giving object becomes hostile in the patient's eyes." Interpretations must be given very carefully in this situation, advised Stern. Illusory improvements occur on the basis of positive transference. The rise in self-esteem at what the patient interprets as approval, commendation, or preference of him by the therapist, the magical figure, is marked. (This is a typical reaction of the borderline patient. The patient's defense is "I am not rejected, I am preferred," and this is an aspect of the transference. The lack of proper peer relations make it important for group therapy to be included in the treatment regimen of the borderline patient at an appropriate time [see Wolberg, A., 1960; 1973, pp. 251-255]).

The handling of negative reactions to interpretations, according to Stern, lasts for a considerable period. "When some familiarity with the unpleasant material should have come about through reiteration, and some acceptance should have resulted, the patients for a long time react as though

it were novo.” (This is the defense of denial in operation.) The anxiety of facing the reality situation has been avoided at the expense of pain, for example, a depressive reaction. To achieve a successful performance means a violent suppression of neurotic inferiorities and the assumption, which can sometimes be detected, of the role of some highly envied omnipotent image. Freud understood this reaction correctly when he attributed it to obsessive characteristics and anger—I would say anger turned into rage.

A negative therapeutic reaction, Stern pointed out, can be discerned in the patient’s taking interpretations as an attack. As we have mentioned, this reaction often occurs when the analyst makes a direct interpretation that is premature. The reaction is a defense. With the borderline, I have noted, direct interpretations must be related to preconscious ideas rather than to more remote unconscious material that one might deal with in the case of the neuroses, although I suspect that the former type of interpretation is wise also in the neuroses. One should not make “deep” interpretations to the borderline patient at first, for through his defenses he has “chopped up” his concepts, so to speak, into pieces and parts. This is what Freud referred to in his concept of “compartments” in the obsessive personality. We interpret the pieces and parts later, putting them into a series of wholes. The borderline patient should not be considered naive, as Stern suggested, but *wiley* in the sense that he tries to control through the defense of idealization or appealing to the grandiosity of the other person. This is an aspect of the defense of

projective identification. When guilt overcomes the patient as he takes the part of the powerful person (what Stern has said is the role of some highly envied “omnipotent image”), he then attacks himself (the “suffocating superego” is operating).

As a result of frustration, Stern wrote, the borderline evidences insecurity. As children, borderlines have stronger “affective fixations,” oedipal and preoedipal, than those who have experienced understanding and love. During therapy their character traits are the main sources of emerging problems that are “clinically so stormy and so difficult for both patient and analyst.” Once the “affect hunger” is recognized in the transference, “many other phenomena group themselves about it and become at least comprehensible even though not always accessible as we would wish.” “Affect hunger” is, as I have pointed out, a characteristic of the frustrated individual, but this trait persists because it becomes fused with the individual’s later revenge feelings and sadism. We deal with an “insatiable person” who is an “angry person” fired by revenge feelings rather than being “needy” as an infant, or “fixated in the oral stage of development” (“fixated” or “arrested” in development). The passive trait of “neediness” has turned into active exploitiveness and an acting out of the revenge motif.

Stern ended his treatise by saying that in treatment the positive transference is limited by the poor capacity for object love. The analyst,

therefore, cannot play a passive role. If these patients lie on the couch, they maintain their accustomed withdrawn, detached states interminably; they remain protected against transference involvement.[8] Most of these patients' early activities in treatment, according to Stern, are aimed at "winning over the analyst." Another way of looking at this is that the patient tries to control the analyst through the "winning-over" mechanism. Actually, the patient tries to get the analyst to act out with him and become involved in a sadomasochistic pattern while at the same time he wants the analyst to fight against the control. Above all, the patient hopes the analyst will *not* indulge in a tug of war for this will reduce the patient's chance to be treated.

"When the patients were silent, I attempted to explain as best I could the significance of their silence," said Stern, "but this did not always help ... I came to realize that these patients did not need to learn, that in fact they already knew a great deal about which they were *guilty or terrified*" (present author's italics). They needed an "easier relationship with me." What they needed from the analyst, asserted Stern, was *help in lessening their guilt and fear* so that they could reinvest their thoughts with more appropriate emotion. How to give them this help was the problem. (In my opinion, this can be done only by working through the masochistic pattern using consistent and varied interpretation of the transference in the patient's contact with others and finally with the therapist, eventually connecting these with the patient's relationship with parental figures.)

It was important, Stern continued, that the analyst bring about a *reality-oriented relationship,* essentially different from the original parent-child relationship. In this way these patients might obtain more assurance and courage to face their painful affects. This is like the "corrective experience" later suggested by Alexander (1940,1948) and Alexander and French (1946); it also correlates with the ideas of Clark and Kohut and the findings of Betz and Whitehorn (see pp. 9-10, 288). In stressing "reality factors," however, we are referring to discussions of the patient's defenses, his fears and angers, the way in which his *current situation* is affected by his sadomasochistic attitudes. We are not referring to a discussion of how he distorts reality, confronting him with his distortions. We must remember that distortion of reality is a function of *conflict, anxiety, and defense*— not a sign of missing ego functions. Stern equates the projection of the borderline with difficulty in reality testing. (Does my patient Harriet Hamburger not see me as I really am? I believe that she does, even though she acts toward me as if I am somebody else when she calls me twenty minutes after the session to see if I am "all right.")

Stern noted, as I have often seen, that when the borderline thinks of independent action, anxiety is created that is not easily handled. The anxiety, I believe, is related to sadism. On the one hand, the anxiety is motivated by the desire to outdo someone by way of secretively expressing revenge feelings which originally related to the parents; on the other hand, the anxiety is evoked by *guilt* in anticipating the stepping out of the neurotic role and thus

to change by way of the therapeutic process. (See the sessions with Daird and Kurt Blau in Wolberg, A., 1973, pp. 183, 215, 221.) The usual pattern in making forward moves is to engage in obsessive behavior in order to defend against anxiety associated with guilt and revenge. Some patients use *action* to quiet their anxieties in dealing with feared authority figures—a kind of counterphobic mechanism mixed with the need to employ control mechanisms to express the "self" or "I" as opposed to the authority. The action employed is constructive sometimes, but usually it is oppositional in nature, even though on the surface it appears constructive. The oppositional behavior is a statement, so to speak, of the individual person as opposed to the authority who tries to control. Passivity as negativism also gives the individual a sense of *being someone* and of *having power* as a separate entity. Especially in the first three years of long-term treatment, I have recommended that independent action be discussed with the patient in advance of his attempts at such actions, with emphasis on the anxiety and guilt that it may create. In order for the patient to reach autonomy separate from the sadomasochistic interlocking defensive patterns, he must recognize how his oppositional tendencies, in whatever form they take, create a transference problem in the treatment and hinder him from attaining his therapeutic goals (see Wolberg, L., 1980).

During the sessions the patient will talk on incessantly, said Stern, and if interrupted by an interpretation he will, as a rule, become angry and anxious.

(This is the patient's use of his oppositionalism creating the negative therapeutic reaction so that the analyst cannot pierce the patient's defenses.) It is essential to control the transference, admonished Stern, keeping at a minimum its negative or disturbing aspects. Stern is correct here. One interprets anger in the beginning only by raising the possibility of its existence as if the patient felt that he *should not* or *could not* express the anger. The therapist can mention that many people typically express anger indirectly in some way. One must realize, however, that to incite the patient to express anger, or to ask *why* he expresses anger, is merely to stir up and to create the need for further defense. If the patient responds with anger when urged to do so, this merely provides catharsis. When the anger is openly expressed, without urging, the problem is even more difficult since this is a spilling over of rage that must be leveled at any target. It has been called "raw instinctual rage"; this rage is complicated, however, since it is a paranoid reaction and, therefore, a projective defensive reaction.

The paranoid reaction is, in reality, an obsessive use of rage to fend off closeness in the treatment, which is frightening to the patient. The relationship is sadomasochistic. A "warding off" creates frustration for the therapist and "sadistic pleasure" for the patient. At times the session is sexualized, but unlike certain homosexuals and some schizophrenics, the borderline patient does not sexualize the majority of his relations with the therapist. The sadomasochistic pattern is associated on the sexual side with

the patient's perverse pattern and on the nonsexual side with distancing mechanisms, acting out, and revenge feelings when the therapist is seen as stepping out of the "good-person" mold. Even though there are these paranoid-like reactions, the borderline patient in his sexual life retains a relationship with a member of the opposite sex. The male patient may have periods of abstinence and impotency, or the female patient may be frigid. The derivation of these perverse patterns, as I have said, are to be found in the sexual use of the child by the parent. The patterns are sadomasochistic. The question of perverse sexuality was not developed by Stern in his writing concerning the borderline. As a matter of fact, there is little on this subject in any of the current literature. Stern's observations were concise and seem to be similar to those made today. In his writings he did not expand on therapeutic techniques as Kernberg and Kohut have attempted.

Freud's Concept of Perverse Sexuality

We have to return to Freud to find any suggestion as to the dynamics of perverse sexuality, and Freud was vague as to the derivation of certain of these problems. He did associate impotence and frigidity with seduction, but he apparently gave that up—but not quite, for later in his writings on female sexuality and on the development of the male libido he alluded to the possibility that servants might be responsible for the heightening of the sexual impulse in preteen years. He never took the step that would lead to an

interaction theory as the basis of the child’s neurotic patterns, with the parents as contributory partners. His object relations theory was one that emphasized the instinct seeking objects, the hapless object being a responsive but usually benign influence. It is my thought that symptoms such as impotence, frigidity, and others that Freud encountered initially in his patients had a perverse element. In his early studies he credited these patterns to hysterical phenomena; indeed, we see the same hysterical patterns today. There has been no consideration of the possibility of these patterns having a perverse side because in Freud’s work he stressed only the obvious perversions: homosexuality and fetishism, for example. Later when he developed his preoedipal theory and began to write of the “self ”or the self-preservation instinct and the development of the “early ego”, he conceived of the concept that “somatic symptoms” were somehow connected with hypochondriacal ideas. They were an outcome of the preoedipal phase of development, particularly the early autoerotic phase (Wolberg, A., 1973, p. 15), which would mean the “libidinalization” of “part objects.” The concept that Levy (1932) suggested would be a use of the child (object) on the part of the parent in the latter’s gazing or wandering with the eyes over the child’s body, whether the child was dressed or undressed, and this would suggest a peeping perversion. We know, of course, that peeping is never connected solely with eye meandering and that an acting-out pattern is usually associated with it as well. It is interesting that Freud touched upon the

dynamics of this kind of perverse behavior that is associated with masochism and with sadism. The bodies of children have many and varied meanings to neurotic parents, and for borderlines this meaning pattern is important in the analysis of the perverse sexual behavior.

Freud wrote that the origin of perversion is in the oedipal situation (Freud, S. E., 1919, pp. 192, 196). His interest in sexuality began early in his psychoanalytic career and continued throughout his writings. The sexual problems of his patients were what stimulated his curiosity in the beginning and accounted eventually for his developmental theory. He recognized that the rearing techniques have a great deal to do with sexual life, that is, the way in which the original sexual stimulations occur, the way in which the mother handles the child's body, and so on. In the end, however, Freud seemed to put as much importance, if not more, in his theory of a bisexual constitution, which he regarded as an element in all people. He seemed willing to attribute active sexual seduction to nursemaids and servants but not to the parents themselves. Freud proposed that the psychological aspects of bisexuality could be seen in the child's identifications with each parent during the oedipal period. As a matter of fact, Freud assumed two meanings in his concept of bisexuality: (1) an actual biological or constitutional bisexuality, using his concept of *active* and *passive* relating to male and female trends in all people, and (2) a relation to sadomasochism (never made clear) where every person's character had some connection with the stages of sexual

development through which the individual had to pass. According to this theory, we all have male and female characteristics, psychologically speaking, as we all attempt to resolve our developmental problems. Also, we all have sadomasochistic instincts that weave their way through sexual development and are resolved for practical characterological purposes during the oedipal period when the superego begins to take form. An interaction theory such as I have proposed would implicate the parents in the organization of the neurotic pattern, a pattern that would not be *set* in infancy but would be conditioned *over time* by the neurotic needs of the parents and their behavior relating to their efforts to relieve the anxieties associated with those needs. The defenses of the parents of borderline patients are such that they contribute to the borderline's main defensive pattern—*projective identification.* As I interpret projective identification, it is a defense that is organized over a long period of time before it is finally consolidated. Perhaps in meta-psychological terms we should speak of the identification part of the ego as a dissociated part when it is seen in the borderline patient. We would say *dissociated*, not in the sense that "splitting" is a defense in infancy prior to the institution of repression and in the borderline, therefore, a preoedipal phenomenon, but in the sense of its being a hysterical phenomenon, an internalization of the neurotic experiences with the parents, a persistent phenomenon related to acting out of the roles that the parents not only project onto the child but over time condition him through punishment and

reward to accept. The acting out can take many different forms depending upon the parents' problems, the environmental situation at home, and the conditions in the community where the home is located. Projective identification, as a process, however, is much more complicated than simply an acting out of roles and internalization of these roles; it also includes the defenses that surround the identification roles— denial, dissociation, repression, and displacement. Symbolization and distortion are included in the projective aspects of the defense.

Freud thought that the oedipal problem per se is to be considered only as the child works through his conflict with the parent of the opposite sex, but in projective identification we see conflicts with both sexes and perverse behavior as an identification with both male and female parents. Freud's main works on perversion are "Sexual Aberations" (1905) in "Three Essays on the Theory of Sexuality," "A Child Is Being Beaten" (1919), and "Fetishism" (1927). It is perhaps not sufficiently understood today that various forms of impotence in men, and certain aspects of frigidity in women, may have a definite relation to a sexually perverse trend. The masturbatory activities of these patients or the masturbatory equivalents are factors in the perverse sexual life of the patient. This can be detected through the fantasies, the dreams, and the patient's associations, as the sexual conflict with parental figures unfolds. In his theory of sexuality Freud placed emphasis on constitutional factors in relation to perverse trends.

The working through of the anger that is associated with a paranoid trend, and thus with a perverse sexual pattern, is a difficult process. It includes an understanding on the part of both the therapist and the patient of the psychodynamics of sadomasochism and the recognition of its defensive nature. If the patient shows a denigrating attitude toward the therapist, this is a defensive maneuver and a transference reaction that has a perverse quality. The patient is acting toward the therapist as if he were the parent and the therapist the guilty child. This is an *acting out,* however, and makes direct interpretation of the transference ineffective. *This acting out represents, in part, a conflict over the feeling toward the parents ' perverse nature, and in part it is a conflict over self-assertion when to act as one would wish goes against the parental mandate.* The acting out is also a counterphobic maneuver to overcome the guilt and certain inhibitions inherent in accepting the parental admonitions. Freud (1909) touched on such conflicts in one paper where he discussed the case of the young man who wanted to marry a woman "different" from the one whom he had been "in love with." The second woman was more to his liking. He interpreted his preference of the second woman as a possible aggression against his father (who was dead). The patient said that if he chose the woman he wanted, some harm might come to his father. The patient had to determine whether his choice was free or, in fact, based on anger and revenge. The patient's conflict was related to an early but unresolved problem with his controlling father. When anger and aggression

are actually worked through, the revenge and sadism are exposed and recognized. This cannot be done with the borderline patient until late in the analysis. Interpretations, in the treatment of the borderline, are repeated over and over in various forms, at various times, with various meanings, until these patterns are crystal clear. In the need for repetitive interpretations as the patient acts out the patterns representing the derivatives of early experiences, patience is the watchword. The tendency of the borderline patient to somatize makes it necessary to proceed carefully and do nothing in the way of interpretation that will cause undue stress, such as deliberately trying to provoke or frustrate the patient. Premature interpretation creates the need for further defense, which, in turn, creates more tenseness. When the patient is in conflict over a solution to a problem that he must work through, the therapist should not attempt to protect him from emerging anxiety, but neither should the therapist try to evoke more anxiety.

Geleered (1944) studied borderline children and presented a paper describing 7-, 10-, and 12-year-olds who had a symptom of temper tantrums. All exhibited the need to control situations and to be in relation with a woman (a mother figure?) whom they felt loved them or had regard and respect for them. When they were not sure of the “other,” they would break out into what appeared to be a psychotic attack, yelling and striking out, and they would verbalize what seemed like paranoid feelings. They contended that they were being abused, harm might come to them, and they might be killed. The need

to control for fear of annihilation was great. They experienced fantasies of being the most powerful person in the world. A delayed reaction to events and the displacement of anger was evident in these cases (Geleered, 1944, pp. 241-242). It seemed to me that these children had great fears of authoritative, controlling, ridiculing attitudes in other people and fears of their own counterhostility. Their fantasies were sadomasochistic.

It would be interesting to know whether temper tantrums are always present in the early childhood of those who later become borderline patients. It is certain that these patients report feeling humiliated and controlled in early childhood, and they have beating fantasies or their equivalent. Freud felt that the beating fantasy meant that the father was always represented as the beater (in the case of both boys and girls). He thought that these people showed a great irritability and sensitiveness toward anyone whom they might think of as father and opined that we might some day find that a perverse wish toward the father might be a dynamic in the "delusional litigiousness of paranoia." Freud at first felt that masochism was derived from the "sadistic instinct." Later in "Beyond the Pleasure Principle" (1920) he was of the opinion that there might be a "primary form of masochism" since he could not see how masochism could be pleasurable if it depended solely on the pleasure-unpleasure mechanism. If masochism were an instinct, it could not be attributed to interpersonal experience, and thus such a "defect" in sexual development was of a constitutional nature. In the beating fantasy the

problem with the father would be in fantasy rather than due to experience. When in transference the patient was irritable with father figures, the patient would evoke hostility in the figure. This would then create a milieu where his fantasies would be realized.

Kurt R. Eissler

We have mentioned that many of Kurt Eissler's ideas were similar to Clark's. Eissler (1953) wrote about *modifications* in treatment, stating changes are necessary in analytic technique in order to deliver adequate therapy of delinquents and borderline patients. Eissler defined certain "parameters" that appeared to follow some of the same lines as Clark had earlier. The effect of a parameter (a deviation from standard technique), said Eissler, must be such that it does not interfere with the working through of the transference. The parameter might be related to giving encouragement or altering or reducing the frequency of interviews according to the patient's particular kind of problem or to the life style of the analyst. Such modifications do have an impact on the mode of relating to the patient. (Eissler pointed out that the therapist may be involved with meetings, lectures, and the like and thus may find it necessary to cancel sessions.) Another type of parameter might be that the patient would ask questions that the therapist might answer, as opposed to interpretation and this procedure would be a repetitive tool of treatment. Or the therapist might set limits if the

patient is prone to act out. Or the therapist, for one reason or another, might refer the patient to another therapist before the treatment is finished. Other parameters used are education of the patient in the dynamics of the problem (Freud used this technique), explaining a defense or a symptom (i.e., the dynamics of a symptom), and having the patient sit up rather than lie on a couch. All of these modifications are important in the treatment of the borderline patient. In 1952 I suggested sessions once or twice a week for the borderline (Wolberg, A., pp. 701-702)—particularly in the first phase of treatment—and the use of the sitting position. I also advocated explaining to the patient the dynamics of defense against certain reality factors (Wolberg, A., 1952, pp. 706-707).

The use of the couch in the first phase of treatment of the borderline, I find, tends to propel the patient into a masochistic position and thus toward the use of excessive withdrawal into sadomasochistic fantasy. Since fantasies are easily elicited, even when the patient is sitting, there is no advantage in the therapist using a technique that forces the patient into a more extended defense than he ordinarily has. As a matter of fact, the goal of therapy is to help the patient let up on his projective defenses, thus reducing rather than increasing his anxieties and his withdrawal tendencies, which in psychoanalytic terms have been called “regression.” The early psychoanalyst spoke about “regression” as a necessary ingredient of the treatment process. Regression obviously was meant as a retreat into fantasy, thinking of fantasy

as a “primitive” form of expression, but the early analyst did not observe or take into account the detachment and the withdrawal tendencies that increase as the patient “regresses.” (As a matter of fact, the whole concept of regression is one of the many mystiques that continue to clutter the thinking of many analysts. A rational way of looking at the phenomenon designated as regression is to understand it as withdrawal into fantasy, an aspect of the defensive system.)

Eissler, like other writers, pointed out the need for caution in the employment of parameters. He warned of the great temptation to cover up inadequacies (of the therapist) by their introduction since they can, if used inappropriately, represent “one’s own inability to use properly the interpretive technique.” Eissler’s idea of introducing parameters has been criticized by numerous people. They point out, for example, the risk that a resistance has been temporarily circumvented without having been properly analyzed. Defenses, these critics say, are necessary, but the person may have paid too high a price for a defense. They turn to Sigmund Freud’s “Analysis Terminable and Interminable” (1937) and Anna Freud’s *The Ego and the Mechanisms of Defense* (1930) to buttress these opinions. In replying to these critics, Eissler suggested that the deleterious effects of defense on the ego should be called “ego modification,” a concept of Freud’s concerning certain kinds of defenses, particularly the *projective defenses* used in the “narcissistic neuroses” and the psychoses. It is precisely to deal with “ego modification” (a

term used by Freud to mean almost exclusively projection that tends toward delusion or that becomes delusion) that a deviation from standard technique is needed. The borderline patient can have psychotic episodes (mini episodes), and in working with such cases the treatment process may be stretched out for years. While these instances are rare, they do exist. One of my patients, Harriet Hamburger, was one such long-term case, having finished analysis after being in treatment for twenty-two years. After a tumultuous early life and unsuccessful marriage, she is now happily married and is employed in satisfying and lucrative work. Lydia Ranson, who was not my patient but whom I followed through supervision, was another such individual. Her acting-out patterns were dangerous to herself and so persistent that she failed in her therapy with two very good analysts who gave up, feeling that she was a hopeless case. Persistence and help from a sister over a long period of time and analysis with a third analyst who was sympathetic to years of treatment, with group therapy as an adjunct, produced great changes in her. She had the additional problem of being an alcoholic at one point, and with the help of a friend, also an alcoholic, and her sister, she became a member of Alcoholics Anonymous. Today she is a changed person having continued her studies in a university (she had in her early years been a dropout from college), receiving a diploma. She now functions as a trained counselor working with children and adults who have alcoholism as a problem. She uses music therapy as an adjunct with some of

these patients. She has been abstinent from alcohol for years. Characterologically, she is almost completely reconstructed.

Eissler contended that when “ego modification” takes place “the whole process [of analysis] is conducted in the face of most strenuous opposition.” He referred to Freud’s essay on “The Loss of Reality in Neurosis and Psychosis” (1924), and he emphasized that the *the ego of the psychotic must defend itself constantly against the perception, recognition, and acknowledgment of objective reality which precipitates great anxiety.* This need to defend against “objective reality” is an important point that many therapists do not understand. It is one of the reasons that some patients take many years to work through their problems.

Eissler emphasized that reality is ever impinging and that confrontation with reality is an ever present threat so that the struggle is against the pain that could result in the recognition. One is reminded here of a statement attributed to Ovid, “We are slow to believe what hurts when believed.” This is an important statement to keep in mind when treating certain borderline patients, for resistances or defenses are extremely strong, having been organized because reality did indeed hurt the patient. The need to defend against certain aspects of reality is a dynamic in all neuroses, character disorders, and psychoses, but the defenses in each of these cases should be thought of as on a continuum of increasing complexity. In the neuroses

projection is present but not as persistent as in the character disorders, and in the character disorders the projections are not as complicated as in the borderline cases. This pertains to all of the defenses (i.e., denial, displacement, repression, undoing, and so on). As distinguished from the psychotic, the borderline patient does not have persistent and chaotic defensive distortions of reality, i.e., delusions, hallucinations (Wolberg, A., 1952).

Eissler pointed out the need of the psychotic person to hang onto hatred and never to reveal the tender side of his nature (1953, pp. 130-131). The borderline, too, has this characteristic to some extent. Both Searles (1963) and Kohut (1971, 1977) have stressed this fact. This use of aggression explains why the "schizophrenic ego" is a masochistic or self-destructive one, Eissler contended. My impression is that the borderline's excessive aggression, like the schizophrenic's, is a reaction to the aggression of the parents— that is, their controlling tendencies and punitive attitudes, particularly the projections of their own aggression and guilts to the child that the child finally adopts, becoming aggressive through his frustrations. Freud (1938) felt that holding back aggression leads to illness. Originally this was thought to be a problem in the hysterias (Freud, S. E., 1893). "Recall with affect" was considered important in reducing symptoms, the "affect" being tinged with a certain amount of anger (Wolberg, A., 1973, pp. 10, 16, 22-23). It is certain that Freud did not mean that one should express aggression freely. Rather he meant (1), as Breuer had suggested, insults from others if

not responded to in some direct way left the individual in a state of "mortification" (Kohut would say lowered self-esteem), and (2) self-assertion, which Freud, like many others, often equated with aggression, was a manifestation of the ego instincts or the "selfish instincts" as opposed to the love instincts and in treatment these must be fused, or more precisely, sublimated.

Clark seems to have equated self-assertion with aggression when he spoke of the "ability to maintain real aggression," by which he meant self-assertion. Actually, in defense anger and revenge feelings often are fused with the desire for self-assertion, for when one has been belittled or insulted or disregarded, one often feels angry. The child is in no position to retort when the parent is the chronically demeaning person so he must resort to defense, which is a less satisfactory but necessary mode of adaptation. Freud said that "necessity" was the educative element that had to do with some of the reactions of the individual. By this he meant the exigencies of the environment caused the individual to react in particular ways and thus had an effect upon the character of the ego. Here Freud seems to have contradicted his basic thesis that heredity was more important than environment.

The "observing ego" in certain patients including the borderline is, Eissler claimed, weak or nonexistent (this seems to be the opinion of

Kernberg also). As an example, he cites one individual (obviously a psychotic) who remarked, “I could rather believe that you or the world around me do not exist than assume that the voices I hear are not real” (Eissler, 1953). He refers to Waelder (1934) as being in agreement with his own idea that the schizophrenic “has lost the ability to differentiate between the possible and the real in certain sectors of reality.” It should be pointed out that if one looks at the patient’s production in that manner, then one’s response would be different than if one feels that the meaning of the remark is that the patient *can* distinguish fantasy from reality. Denial, repression, and distortion mask the observing ego (see my session with Maurice Belk, in Chapter 11)— *but it is there.* And it is for this reason that projective therapeutic techniques are so important at particular times. *The skill of the therapist in determining the least defended areas of the patient’s productions is the clue to keeping in touch with the observing ego on the preconscious level. The ability to understand when the patient is speaking of a particularly anxiety-provoking problem that he verbalizes but cannot face, yet wants on some level to discuss, is the key to disclosing the observing ego as the patient defends with the mechanism of projective identification. In the latter type of situation the projective technique is most useful and essential, for it is through this technique that the patient realizes that his problem is being understood.*

Understanding is revealed in the projective interpretations. The patient “knows” he is communicating with the therapist, even though he is denying

and protesting against this at the moment. In my interview with Maurice Belk in Chapter 11, Maurice talks of his son's acting out, referring to the behavior not as neurotic or impulsive, but *as behavior that he can understand.* He can also understand the attitude of his son's doctor. He does not delve deeply into the relationship, for his message to the therapist is that he must act out, otherwise he cannot live. He scolds the therapist for not listening to this communication.

The interview with Belk could be thought of as a disjointed and fragmented session, a session where the patient jumps from one subject to another, a session that leads nowhere. Actually, the session tells a great deal about Belk, his anxieties, his patterns, and how he handles his relations with people. Even though it seems disorganized on the surface, there is a theme and a communication that is clear and expressed, albeit by using the "other" (in this instance his son) as the projective vehicle through which to express his thoughts. The patient's protest that "they don't listen" applies both to himself and to the therapist. He is in essence saying, "You are not listening to what I am telling you. You are talking in another way, and about something else." With Belk I handled this protest by referring to people who do not listen, people who are talking with each other but at cross-purposes. I also described the way that some people feel that they must act out. It relieves their tensions, and they do not believe their tensions can be relieved in any other way, except perhaps by pills.

The explanation to Belk might be thought of as the use of parameter. I believe it is a form of interpretation since I was relating my remarks to communications I received from Belk in the sessions. Before we can make connections with the childhood experiences of borderlines, we must establish (1) what the patient accomplishes and feels about acting out, (2) what the acting-out patterns are like, and (3) their relationship to the identification fantasies and behavior. Interpretation must be made in common-sense terms. Prior to this we have to outline the *interlocking defensive system* that the patient sets up with others. And this I did with Belk.

Eissler explained that the patient’s incapacity to use his observing ego to pull himself out of the context of defensive phenomena makes the technique of treating severely ill patients essentially different from that of treating neurotics. Thus one extends the treatment parameters to the treatment of *ego modifications* (Eissler, K., 1953, p. 241). We know that the borderline patient’s defenses do not extend to fixed organized delusions and hallucinations (Wolberg, A., 1952), nor are these patients excessively and obsessionally bent on a pattern of destroying some person or group as in the case of the paranoid. Therefore, we understand that the borderline uses a more attenuated defense of projective identification than the psychotic, and a projective technique employed by the therapist is a recognition of this fact. I have introduced projective technique to recognize the presence of the patient's *ego functions* and his *observing ego*, albeit in the context of defense. I

illustrated (1973) that one explores the situation that the patient talks about and then elaborates on incidents that the patient describes and verbalizes, discussing the latter in the context of the "other" keeping in mind the patient's denial and the projection of his identification images (see the sessions with Lisa in Wolberg, A., 1973, pp. 208-210). I do not consider the projective therapeutic technique a parameter; rather I consider it an analytic procedure that allows the discussion of the patient's problem in dynamic terms through the use of the "other" with whom the patient is identified while he is denying the identification. The observing ego is ever present, just as the capacity to understand reality is extant (Wolberg, A., 1952, 1960).

The projective technique (Wolberg, A., 1973) can be used simultaneously, in the same session, with other more direct psychoanalytic methods. When the patient's productions show preconscious awareness, we can employ a direct statement for interpretation or emphasis; but when the material is highly defended, we use the projective technique. As a matter of fact in the early stages of treatment, we use both direct interpretation and indirect interpretation (projective interpretation as an aspect of the projective technique) alternately in the same session. We also use the technique of reinforcement of the patient's positive ideas in both direct and indirect ways.

Annie Reich

The work of Annie Reich illustrates that psychoanalytic concepts regarding the narcissistic disorders have changed little since she wrote her paper in 1953 entitled “Early Identifications as Archaic Elements in the Superego.” And much of the current theory continues to be the same as it was in Freud’s day. The new information that is available today on these disorders has had little effect on the mainstream of psychoanalytic thinking.

Reich’s (1953) paper is a psychoanalytic interpretation of what we might now call narcissistic or borderline personality. Reich distinguishes between the *superego* as a later and more “reality-syntonic” structure and the *ego ideal* as the predecessor of the superego or a more “narcissistic superego”— the distinction between (1) “identification with parental figures seen in a glorified light based on the child’s longing to share or take over the parental greatness in order to undo his feelings of weakness” and (2) identifications resulting from the breakdown of the Oedipus complex. The former represent the ego ideal; the latter, the “true superego.”

In this formulation, as in Freud’s ideas, the impetus for the identifications come from the child as one of the automatic behaviors associated with growth and development. Actually, these are compensating devices as described—or, what I would call, defenses. Freud, however, considered the “ego ideal” and identification necessary and “normal” phenomena in the development of the ego. In my opinion the young infant or

child would not “normally” have such feelings of inferiority with the need to identify with a strong parent; rather, the young infant or child “normally” would feel secure. The identifications with a powerful figure would come at an age much later than 4 or 5 months, or, when the unresolved oedipal symptoms are presumed to begin, and they would be a defense against the neurotic need of the parent for the child to take over some of the characteristics of the parent, i.e., the neurotic roles that the parent wishes to deny. The child would resist this as long as possible, but he would eventually have to “give in” and adopt the role the parents project onto him as they communicate their need. The identifications would not be sought as a means of growth and adaptation; rather they would be accepted under protest, causing anxiety and anger, resentment, and despair, thus providing the basis for the individual’s future neurosis.

Reich believed that identifications leading to superego formation are related to the oedipal problem and are identifications with the moral side of the parent that are used for repression of oedipal strivings. Identifications can be positive (do what your father or mother does) or negative (do not do everything that your father or mother did). Such activity as aggression toward the objects is eliminated by “putting oneself in the objects’ place,” and it is in this way, Reich thought, that character traits of parental figures are taken over that are no longer connected with the task of instinct mastery. By this simplistic formulation and mystical circuitous route, using the litany of

psychoanalytic early-phase doggerel, Reich arrives at a description of symptoms related to the narcissistic personality. But in her model she has circumvented the complicated family dynamics involving the struggle that takes place over a number of years as the child fights against becoming the projective object for the parents, i.e., identifying with the parents and acting out the neurotic roles (identifications) that will relieve the parents' anxieties. In Reich's neat little world aggression accruing through frustration by the parents is resolved by "putting one's self in the place of the other." True, identification is a defense. It does not, however, entirely reduce the aggression, for the aggression is needed both by the parents and by the child and is absorbed in the sadomasochistic (passive-aggressive) character pattern, which evokes acting out at certain points.

Freud, according to Reich, insisted that the choice of identification used for the formation of the superego is determined by the degree of bisexuality present and also by the pregenital history. The "instinct restraining" identifications. whose task it is to hold back incestuous genitality, become fused with earlier identifications against "pregenital indulgence"; the identifications that substitute for the parents as objects of love or aggression become fused with the more primitive ones, and an integration takes place. Early identifications are with "parental qualities" that are envied or admired, and thus they help to undo a narcissistic hurt.

One must realize that “narcissistic hurts” do not a neurosis make, unless these hurts are practiced by the parents over a period of years and in a persistent obsessive manner with punishments for certain normal behaviors when these interfere with the child’s adoption of the neurotic role that the parents wish him to play. Lack of self-esteem does not derive from mild ordinary everyday punishments that are aimed at not letting the child hurt himself or that protect him from other kinds of harm. Normally, the child does not “long to be like the parent”—why should he? In identifications he is forced to be like the parent, or, more precisely, he is forced to do what the parent wants of him as the parent forces him into the passive-aggressive sadomasochistic neurotic role.

Even though early identifications, said Reich, come about because of feelings of inferiority, helplessness, and envy of the power of the adult and later as a consequence of oedipal strivings and even though they represent a “normal longing” to be like the parent, an idealized parent, these early identifications may lead only partially or not at all to personality traits. These “longings” must be described as “ego ideals.” Self-esteem depends upon them. In the early preoedipal stage the ego ideals restore injured narcissism by expressing themselves predominantly as imaginary wish fulfillment, i.e., “narcissistic fantasies.” In these fantasies the child sees himself as big, powerful, a genius, and the like. These can be elements in a masturbation fantasy. They may become a permanent part of the personality against which

the ego is measured. In the phallic period, for example, the child may experience a trauma (sudden threats to narcissistic intactness) and cause the main part of the libido to be withdrawn from love objects and become concentrated upon the ego. This leads to the use of "grandiose ideals and fantasies." The grandiosity is used to "ensure phallic intactness."

My interpretation of grandiose fantasies is that they are defensive; they depict the interpersonal relationship between the parents and the child in disguised form, that is, that aspect of the interpersonal relationship that is chronically traumatic for the child. When the parents need a particular kind of relationship to appease their neurotic needs, they project the role onto the child and force him through punishment and reward to enact the role that is similar to the parental role (neurotic) that the parents wish to deny in themselves. The relationship thus becomes sadomasochistic over time, and the grandiose fantasies develop as defenses against the anxiety aroused in the sadomasochistic relationship. Grandiose fantasies develop out of fear of being overcome or destroyed by the aggression of the parents, who punish repeatedly for normal behavior when this creates anxiety in the parents.

Reich thought that the early identifications were superficial in the sense that they are not associated with trauma but are identifications that occur when the infantile ego is weak and when fusion with strong parental objects ("a magic taking over of the strength of the parent due to the insufficiency in

the child”) is necessary. These are “transient and changing,” (now thought of as “self-images” and “object images”). Reich said that in this circumstance the child simply imitates whatever attracts his attention momentarily in the object, and these imitations express (in a primitive way) “that he is like the object.” A definite wish to be like the object precedes the formation of the grandiose fantasy. It also indicates a “realization of the differences of the self” and the “object.” As these “passing identifications” develop slowly into a real assimilation (internalization) of the object's qualities (a partial identification because the child can never be like the parent in all respects), we see a type of “normal ego ideal.” This will lead to attempts to bring about a realization of the identification aims as soon as the growing capacities will permit. The identifications and the ego ideals divested of the earlier grandiose forms, i.e., the unrealistic aspects, are then “reduced to human proportions." A clinging to the earlier form represents a “fixation” or a “regression” to the early stage of ego development. In pathological cases the “imitation identifications” persist, and there is not even an impulse to translate these fantasies into reality. The step from fantasy to reality cannot be taken because the ability to achieve this goal is not present. There is no capacity to stand tension, to wait to accomplish the goals of this display of fantasy and the adoption of reality. Reality testing may be partially relinquished, and “a state of partial or temporary megalomania” may prevail. A state of inferiority is present, and varying states of depression can be seen. Sometimes these “narcissistic ego

ideals” become conspicuous only in adolescence or at puberty. How this all comes about is not explained by Reich; Freud thought that this circumstance was due to constitutional defects rather than interpersonal relations in the family.

In repression, Reich asserted, object-libidinal strivings are replaced by identifications of the early infantile kind. These “archaic elements” show in the inability to distinguish “good” and “bad.” In the “narcissistic non-psychotic state” narcissistic ego ideals prevail. In certain circumscribed areas the individual does not discriminate between fantasy and reality. Objectivity toward the “self” is lacking. In the “good” and “bad” identifications with the love objects there is no fusion, and this facilitates mood changes between megalomania and deeply self-critical periods. “The sick suffering pregnant mother” identification in one of Reich’s cases was counteracted by the “nonreality-oriented omnipotence” ascribed to the mother. The “sadistic father identification” was counteracted by “good deeds”— the opposite of the father. The narcissistic core of the superego in this case was seen in “narcissistic ego ideals." also: (1) reality testing giving way under certain conditions. (2) infantile feelings of inferiority. (3) megalomania. i.e., an inner feeling or conviction of one’s own greatness,[9] (4) the undoing of the separation between “self” and object, (6) depression and mania (not extreme as in manic depressive illness), (7) fear of being inferior, (8) overconcern with other people’s thoughts about oneself, (9) sadomasochistic fantasies, (10)

oral concerns, (11) sexualization of parent-child relations, seen later in patterns with the opposite sex. I would say that the identifications are pictorialized in the patient's dreams and fantasies and that these are sadomasochistic in nature. The sadomasochism arises, however, not through the automatic appearance of instincts around the age of 2 to 3 years, nor even later at 5 to 6 years, but through the traumatic relations with parents who project their own unwanted (guilt-producing) neurotic activities onto the child and force him to react in kind over a period of years. This causes anxiety, frustration, fear, anger, and resentment in the child, which then must be handled by the defenses Reich has outlined. Much later in adolescence, the resentment is tinged with revenge feelings, which are acted out in a variety of ways.

We shall now consider in Part II current papers that present ideas concerning borderline patients and discuss these from the theoretical and treatment points of view.

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Notes

4 Most of the papers on group therapy with the borderline and schizophrenic patients speak of the patients regressions to earlier phases of development. A great mass of essays have been printed consequently that interpret group process in terms of the structural theory and Freud's concept of infant development. Family therapy as a system concept is a later contribution to treatment literature.

5 This is revealed in the patient’s associations to man and woman drawings, the bigger figure being more controlling and threatening. See the drawings of Harriet Hamburger and Harold Hemple, pp. 238, 249, 255.

6 See A. Wolberg, 1973, pp. 155-161, for a description of the effects of parents' Oedipal problems.

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8 This is a defensive masochistic stance and can be minimized in the borderline patient by having individual sessions once or twice a week using the sitting position (see Wolberg, A., 1952). Excessive defensiveness must be reduced before an extensive working through of the hostility can take place.

9 In reality, Reich's patient had graduated college summa cum laude.