SPECIAL PROBLEMS

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Table of Contents

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This chapter is a review of selected papers on the borderline condition. Except for the research papers, one finds the authors utilizing current theories to explain particular problems that arise in the treatment of this patient. In anticipation of the discussion of modern developmental theory in Chapter 5 and the critique of Freud and Mahler's developmental systems, I am suggesting in this chapter other alternatives that I think may be useful to the therapist who is working with the borderline patient.

Research

The main research data on the borderline comes from several studies—Grinker and Werble (1968, 1977), Gunderson and his colleagues (1075 a, b, c) and Spitzer and his associates (1979). The information is mainly descriptive. Gunderson, Carpenter, and Strauss (1975 b) compared 24 borderline and 29 schizophrenic patients. The results showed that 45 percent of the borderline patients displayed depressive delusions; 45 percent, paranoid delusions; 60 percent, dissociative symptoms (derealization episodes in 20 percent, depersonalization in 40 percent); 20 percent, hallucinations and 7 percent, delusions (organized and motivating). I am of the opinion that when

organized delusions are present and are motivating the person, the diagnosis is schizophrenia rather than borderline. In the Gunderson study depression was the most frequent affective symptom. Anger and anxiety were also present. For the schizophrenic patients anger was less a problem than depression and anxiety. (Depression is probably a defense against intense anger. I The borderline patients themselves reported anger as a symptom, but the interviewers noted more anxiety and depression. Grinker's study showed anger to be a central emotion.

Gunderson et al. found that the borderline patient led a "frenetic stormy life style" punctuated in some instances by unusual or occult experiences. While the borderline patients had some psychotic symptoms, these were "circumscribed and experienced by the patient as alien." The borderline patients "showed significantly fewer psychotic symptoms than the schizophrenics." (In my 1952 paper I noted that some borderline patients have what seem like hallucinatory experiences with religious or ecstatic states, but these are fleeting. Kety has suggested that borderlines can be placed on a continuum, at one end nearer to psychotic and at the other end nearer to neurotic. (Interpersonal difficulties were acknowledged by most of the borderline patients in the Gunderson study. Suicidal threats, doubts of self-worth, somatic complaints were quite common. In the year before admission these patients had worked three-quarters of the time, had met with their friends about once every three weeks, and among the unmarried

had dated fairly regularly. Prognostic variables of known importance to schizophrenia were in the moderately favorable range for the group of borderlines.

Depression

Authors who use current psychoanalytic developmental theories feel that the borderline patient does not have depression but rather has an apathy. We have mentioned that the implication is that apathy is a state related to the "separation-individuation phase" (occurring from 12 to 16 months of age) i.e., a preoedipal phenomenon, while depression is a state accompanying "oedipal anxieties" and guilt; thus it is a factor in the developmental stage in the 3-year-age range. These concepts are based on Mahler's refinements of Freud's developmental scheme where "higher and lower" stages of mental or "ego" development are presumed.

Following current ego theory, some authors consider the analyst, in the treatment process with patients who are "fixated" at this early stage, to be an *auxiliary ego* (Mahler), or an *auxiliary superego*, or both, while others suggest that the analyst is a *"transitional object"* (Winnicott). There are those, such as Boyer and Giovacchini (1967), who say that the analyst is an object with whom the patient may "identify" in order to change "harsh punitive introjects" into "good and kindly ones." And some analysts, as we have seen,

feel that the analyst must function as a mother. Those who follow Kohut's theory separate sexual development from the development of self-esteem; these are two distinct lines of development, but the question of guilt is not emphasized. However, Melanie Klein's concept of early envy is used. When Freud (1915-1916) was developing the libido theory and expanding on his concept of narcissism and his ideas about the ego, he suggested that there are two kinds of instinctual development out of necessity. Also he proposed two kinds of identification: (1) the hysterical kind and (2) the narcissistic kind (Freud, S.E., 1917, 16:428). He posited autoerotism as the original physical state of the infant (1917, 16:416) and megalomania as the "feeling state" (16:415), which he compared to a later overevaluation of the object in "normal erotic life." Narcissistic identification had something to do with a "lost object." It was a compensation, so to speak, for the lost object. It is my thought that the object is "lost" due to the rejection of the child by the parents and the strongest identification is that with the most rejected parent (Wolberg, A., 1968, pp. 105-107). The sense of rejection can begin early in the child's life, and idealization of the object is a defense accompanied by a feeling of unworthiness, which is the beginning of a later persistent feeling of low self-esteem the defense against which is grandiosity or megalomania. Freud had the idea that a "narcissistic identification" is projected onto the ego (1917, 16:427). Perhaps he thought that the idealization of the lost object was somehow taken into the self, becoming the megalomania of infancy. It is

difficult to understand just how Freud did conceive of the dynamics of this early phase of life. Although Freud suggested two lines of development, he nevertheless, unlike Kohut, considered that these were fused or at least that they were eventually in harmony. The ideas that Freud expressed in his lectures 22 and 23 (see Freud, S.E., 1916, 14:311-331, 1917, 14:239-258) dealt with these metapsychological schemes, and in lecture 24, he returned to these ideas again (1917, 16:7; 412-430). We shall see in Chapter 5 that these concepts of early development are slowly but surely being questioned and refuted.

It is the loss of object or more precisely *the feeling of being rejected and abused* that accounts for the borderline patient's depression—a mild depression. There have been many articles in the literature pointing to the devastating effects of depression in one member on the other family members. The depression of the borderline is not deep, but it is *chronic*—a reaction to life's stresses. This is reflected in the hopeless attitude the patient has toward doing anything that will change his situation. He feels encased in a sadomasochistic bind, and in interpersonal relationships he depends largely on "the other" for his cues for activity. He has been "programmed." by his parents, to look to them for his cues for behavior, and he carries this through, in transference, with others. He is most resentful at being in this position but has the feeling that it is his lot in life. His parents have made him understand that they need to use him as an instrument in the service of their own

adjustment and that, therefore, he must inhibit some of his own normal impulses and give up certain of his normal needs, particularly certain activities that have a relation to peer groups. If he rejects this position, the borderline is made to feel guilty, and through punishment he learns to conform. His depression is associated with anger and low self-esteem.

In a study at Yale University it was found that children of depressed women, as compared to the children of "normals," had more problems in school, were more overactive, got into more fights, and had a larger number of accidents. It has been observed by several authors that the mothers of borderline patients are angry, combative, and depressed. Husbands who are in the unemployment category are prone to depression, and with unemployment for more than nine months, the individual often develops problems of self-esteem and sexual impotence. After two years of unemployment divorce is a distinct possibility. There are many divorces in the upper middle class and there are many borderline patients. In the lower economic classes desertion appears to be the rule. There is no data so far as I know on the kinds of separations that take place in these families, but I have found that there are many borderline patients who come from homes where the parents have detached relationships but remain under the same roof. The majority of my own borderline patients come from homes where mother and father have not separated though they often lead stormy (sadomasochistic) existences with periods of detachment.

Descriptive Designations

The borderline patient has been described as an addictive personality, due to his being an "oral character." It is a fact that alcoholics who seek treatment seem to have depressive symptoms and are often in the borderline category, but not all borderlines are alcoholics or have additions. Addiction, it is true, is a way of counteracting depression and detachment, and of avoiding the consequence of interpersonal experience where anxiety is overriding.

Gunderson and Kolb (1978) have suggested variables for diagnosing the borderline patient. Depression was one of the symptoms noted. These authors confirmed many of my own early impressions of borderlines stated in my first paper in 1952. For example, the idea that borderlines maintain relationships with others and are not loners; that these associations are most often with members of the opposite sex; that borderlines are very manipulative; that they tend toward low achievement[12]; that some of these patients have brief paranoidal experiences and certain occurrences that might be considered brief hallucinatory episodes (Wolberg, A., 1952, pp. 694-696); and that they have disturbed interpersonal experiences (1952, pp. 695-700). I find that these interpersonal disturbances are due to the sadomasochistic life pattern which is associated with denial of the good feelings for others, as well as repudiation of the importance of successes and the good outcome of activities or behavior. I also have noticed a kind of

twelve-step cycle (Wolberg, A., pp. 694-6%) associated with what might be called a mood swing in relationships, and I found that reality testing was present, albeit disturbed by anxiety and defenses.

Prior to the establishment of DSM-III, Spitzer, Endicott, and Gibbon (1979) did a research study in an effort to see whether there was enough evidence from practicing psychiatrists for the borderline category to be included in the new psychiatric classification. The study revealed two types of "borderlines"—a "schizotypal personality" and a "borderline personality disorder." My impression is that the first category is probably a form of schizophrenia, while the second designation more nearly conforms to what I conceive of as a borderline. The DSM-III scheme now includes a borderline category.

In a study done at the Postgraduate Center for Mental Health Baumwoll (1979) found that psychoanalysts on the staff who responded to her request produced a list of 278 items related to "borderline patients." This list was returned to the respondents after being given a 5-point rating scale. Clusters were evident under the following headings: *anger, sadomasochism, guilt, fear of closeness* or intimacy, *traumatic childhood, poor self-concept.* The headings were organized around a global use of *projective identification* and a particular symptom picture related to anxiety. The defenses organized around projective identification were anger, masochism, projection, splitting

(dissociation), denial (selective), “black-and-white” thinking, a shifting of defenses, problem-orientated rather than solution-oriented responses (paranoid trend?), idealization, grandiosity. The symptoms were fears, anxiety. complaints of empty feeling (depression; or apathy?), changeable moods, impulsivity. frustration, somatic complaints, intolerance of loss, feelings of danger, suspiciousness, and acting accusatory of others.

The “Defective” Ego

The idea that “the ego" can be defective due to a hereditary factor has been proposed by many authors other than Freud, and this thesis was elaborated by Dickes (1974) in making what he called an “alternate proposal" to the current concepts of “borderline states.” He quotes Freud (1937): “We have no reason to dispute the existence and the importance of original innate distinguishing characteristics of the ego. This is made certain by the fact that each person makes a selection from the possible mechanisms of defense and he always uses a few only of them and always the same ones. This would seem to indicate that each ego is endowed from the first with individual dispositions and trends, though it is true that we cannot specify their nature or what determines them." Dickes (1974, pp. 13) then goes on to say, “It may be added that not only are the choices concerning defense mechanisms laid down at birth but so are the endowments concerning the id and the ego factors involving such matters as intelligence, perception, mobility, etc.”

(Usually when psychoanalysts refer to the “the id” they mean aggression and sexuality that must be held in check by defenses. I Differences in characteristics, Dickes says, have been found in men as contrasted with women. Citing many instances of individual differences, he then suggests that a return to the thesis is in order to the effect that drive endowments differ, as do ego capacities, due to genetic factors. There are some similarities in this idea to the Kernberg proposals that the borderline is “different” and “pathologically so” from birth (Kernberg, 1975, pp. 122-124). Dickes, however, uses many of Kohut's concepts in that he focuses on ego trends and the development of ego functions rather than on defenses per se. He sees this idea as completely different from the continuum idea advocated by many.

Dickes does not like the continuum concept since he believes that it means that one traverses from neuroses to the borderline area and then to the psychotic state, and he comments that, “there is no single road or continuum,” apparently because borderlines are destined to become borderlines from the start. Others feel that if the borderline is a member of an actual category or group, then he cannot have symptoms similar to people in other categories. In order to be distinctive, there must be something unique to characterize the syndrome. The actual fact is that borderline patients do have mini psychotic episodes. But these are temporary and short-lived, and they seem to appear at periods of intense anxiety and stress. They do not have steady psychotic symptomatology as in the case with the chronic

schizophrenic, for example. Freud sometimes called these patients “mixed types,” but he also used the term “borderline” in the last sentence of the introduction to Aichorn’s book (see Aichorn, 1945 [1925]).

The idea that people are foredoomed to be neurotic or psychotic from birth is not new. The impression that individual differences have an effect on whether the individual will become neurotic or psychotic is also not new. It seems to me that if we have a multifaceted concept of neuroses and psychoses, based initially on the influence of social factors, one need not see this as opposing the concept of individual differences nor the idea of a continuum. Some borderlines have had psychotic attacks and so have gone from neuroses to psychoses depending upon circumstances. It is my impression that these psychotic periods occur in the borderline when he senses that he has no control over a given situation. When he cannot have his way or the circumstances are too confronting for him, he becomes angry, frustrated, or fearful due to conflict. The fleeting period of psychoticlike activity is a kind of substitute rage reaction, or it may be a temporary escape from the situation that is too anxiety provoking as in a mini amnesia or depersonalization episode—a kind of “I-am-not-here” feeling or a “this-is-not-really-me” experience, where he saves himself. The saying goes that, among other things, “we all have our breaking point”; that is, it is possible for anyone to have a psychotic episode if the circumstances are dire enough. It takes less for some people to “break” and more for others, and this is a sign that the

traumas and deprivations of the past have created a greater or lesser degree of chronic anxiety in one individual than in another rather than that he is endowed by birth with the precarious condition. From my point of view these breaks mean that the conditions of trauma exist in the present situation and it is not that the individual is suffering only from traumas that accrued in the distant past (see Wolberg, L.R., 1966).

Among psychoanalysts it has become almost commonplace to reject the idea of a constitutional factor in neuroses and psychoses; nevertheless, this is the theory of many authors who have written about borderline conditions. We also find this kind of genetic theory reflected in certain papers concerning the IQ's of blacks as compared to whites. Aggression too is regarded not as a function of a social system, i.e., of relations with people, but of genetic origin. The implication is that we must leave the social system alone and blame destiny for the problem. In practice, however, the borderline patient seems to make a better adjustment when he can depart from his family and get into a more autonomous position. For hospitalized patients it may be that an outpatient therapeutic experience is necessary before such a move can be made.

As far as hospitalization is concerned, there is usually a point at which the anxiety factor is so destressing that the individual must leave the situation. The fact that individuals reorganize readily once they are removed

from the environmental situation that creates the “breaking point" may account for the finding that brief hospitalizations are preferable to long hospitalizations. In general, the latter are said to promote “regression.” There are exceptions to this rule, of course; for example, people who are dangerous to themselves and others and who have suffered chronically for years before hospitalization, such as certain paranoid persons who have become criminalistic and excessively destructive. In general, however, brief hospitalization is preferable to long-term confinement since a long hospitalization is demoralizing. There is an interesting statistic that seems to hold in the case of both hospitalization and brief therapy: one third of brief-treatment patients return to the hospital or clinic, thus two-thirds usually do not; and one third of the latter also return after their treatment has been ended. In my experience brief treatment for the borderline patient, if hospitalized, should last no more than three months with several months of outpatient followup. For nonhospitalized borderline patients brief therapy means at least 30 to 32 sessions. At the Postgraduate Center for Mental Health (an outpatient service) in New York City we found that about 75 percent of our patients can be helped with no need to return in 30 to 32 sessions on a once-a-week basis, and this group included a considerable number of borderline patients. Other patients were being treated in psychoanalysis on a longterm basis (3 to 4 times a week) while the remainder came twice a week.

The Social Factor in Emotional Problems

There is no doubt that people differ in intelligence, in capacities to do various tasks and so on, but both "geniuses" and "normals," rich and poor. Democrats and Republicans may have neurotic, borderline, or psychotic problems. Durkheim (1897) was one of the first to illustrate the connection between social factors and individual character in his study on suicide (aggression turned inward), and many modern investigators, notably Brenner (1973), have established a relation between *stress* as a function of dealing with the vagaries of the economic system (particularly unemployment) and increases in the rates of neuroses and psychoses, criminality, depression, and suicide. Environmental factors are, in turn, a function of the political climate, which creates such phenomena as crowding, poverty, unemployment, wealth, power, and aggression. It was Allport (1954) who said, "Aggression is not a primary tendency to hurt or destroy, but an intensified form of self-assertion and self-expression . . . a secondary result of thwarting and interference." He was only partly correct: aggression is definitely a reaction to thwarting and interference with some of the basic autonomous rights of the individual, but it is an expression of self-assertion only in the sense that aggression is a revenge act after continued frustration. The individual becomes angry at being frustrated and attempts to counteract the frustration or remove the obstacle through his rational efforts; but when this is impossible, he feels trapped. It is then, as the condition persists over time, that the individual

becomes enraged, revengeful, and oppositional and develops neurotic symptoms. Aggression is a reaction after much frustration and defeat. The borderline patient, found in all of the economic classes of our society, has been frustrated mainly by his parents, over time, and he is *revengeful.* The concept of aggression is a topic that embraces innumerable theories and concepts—the two main ones being that aggression is an inherited trait and that aggression is a reaction to protracted frustration. This latter proposition will be discussed in more detail in the section on Harlow's experiments.

Individual differences are factors in human life due both to genetic and social ingredients, no two individuals being exactly alike. No two individuals have the same environment—even in the same family. Lack of opportunity has a great deal to do with certain kinds of individual differences, and this is true for individuals in families of both rich and poor—even in the same family.

The question is often asked. Should not professionals in the mental health field involve themselves in movements, political and otherwise, to alter the environmental stress factors? Obviously, the mental health professional in his or her practice is not a politician; one can influence political events only to the degree that one participates in political movements with others. There was a time when psychiatry, psychology, and social work were looked upon as the means of correcting the ills of society, but the fallacy of such an idea is

now patently obvious. It is true that these fields have at their disposal some attenuated means of reducing the incidence of mental illness, but there are at present two considerations that must coexist if these fields are to make a real impact, neither of which are currently present: (1) the personnel in these fields must have the proper training so that they can utilize appropriate techniques, and (2) a more equitable distribution of income for the general population must be operative so that there is much less inflation and unemployment, the two social components that create havoc in the general society and evoke personal anxiety and stress. Were these two conditions to be corrected, however, it would still be many years before the results of the remedial measures would have an impact on large numbers of the population. Neuroses and psychoses have lingering and persistent effects upon family members and social institutions. There must be several generations of a family who live in "good" social conditions before the long-term benefits can be felt. Neurotic parents will raise neurotic children, but the latter may change somewhat if the parents can give these children a proper social climate. By the third generation there might be considerable difference in character patterns, all things being equal.

Perhaps it is because the idea of a continuum puts less weight on heredity and more on anxiety due to environmental factors as causes of the neuroses and psychoses that Dickes (1974) and others disagree. They credit Freud with having suggested the concept of a continuum. Freud wrote, *"Every*

normal person, in fact is only normal on the average and to a greater or lesser extent and the degree of its remoteness from one end of the series and of its proximity to the other will furnish us with a provisional measure of what we have so indefinitely termed an alteration of the ego" (present author's italics). I believe that if we wish to speak of "alterations in the ego" we should consider this concept in the light of the *defensive processes,* rather than in a developmental sense, particularly according to the degree and kind of the projective defenses: on one hand of the continuum are the less projective defenses and on the opposite end of the continuum the more projective. The problem is not developmental according to a theory of infantile sexuality or special "ego lacunae"; it is dependent upon the nature of the stresses and anxieties created in the individual by his experiences in this world with people and situations beginning in the family. Anxiety and life stress are functionally related to symptoms that have to do with both mental and physical problems (see *Science News*, 1977). The individual and society are interactive from the time of the individual's birth.

Psychoanalysis Should Be a Multidisciplinary Theory

As we have said, Freud considered constitutional factors more important than environmental in his final idea of "greater or lesser normality,'' and the problem of aggression loomed large in his evaluation of the constitutional element. I, on the other hand, would credit the environment

with the greatest importance as a source of stress and anxiety and being more influential in the development of emotional problems than genetic factors. The concept of ego functions accruing or not accruing in the developmental sense has failed to give us understanding of the neurotic and psychotic processes since the concept "ego functions" is so all inclusive that it embraces, besides defenses, such processes as learning, development, perception, and thinking. The use of the term "ego" in this way exceeds the bounds of psychoanalytic theory if we wish to restrict the theory to a specific field. In addition, it is obvious that most people have all their "ego functions" operative as these functions are currently defined (see Wolberg, A., 1973, p. 68). But the defensive systems do organize in different ways, and there is a continuum in the sense that neurotics have less projective and paranoid trends than character problems, while borderlines and schizophrenics have more, apparently in that order.

Freud in his brilliant originality expounded on psychoanalysis as a theory of neuroses and psychoses and the psychological treatment thereof. Gradually, however, he diluted his concepts and. in a somewhat grandiose manner, insisted that psychoanalysis was the basis of all psychology—and indeed of social dynamics as well. The ego ideal, for example, was considered by Freud to be an important concept for group psychology (Freud, S.E., 1914, 14:61). One sees, however, that the "culture" or the social order, or what Durkheim called "collective representations," is what distinguishes the

individual from animals.

In discussing the problem of the environment versus heredity, we encompass in the literature many misunderstandings that contaminate thinking in multidisciplinary circles. Usually this is due to the practice of taking a frame of reference from one discipline and applying it ill advisedly in another field. This was brought home to me by an article I once read concerning delinquency. The author considered delinquency as "normal behavior" because the child was complying with the "norms of his group." If we accept the concept of environment as a factor in the development of neuroses and psychoses, then we come up against the dynamics of society (the group or the social system). It is in relation to the theoretical concepts involving the individual and the group that we discover a plethora of conceptual confusion. The potpourri of biological and genetic ideas and the theory of intrapsychic processes immerse us in many misconceptions. While the field of psychoanalysis is a narrow field, some multidisciplinary and interdisciplinary training is essential. When the idea of prevention is added to the concept of diagnosis and treatment, multidisciplinary theory becomes even more essential. The notion that delinquency is "normal" due to the fact that the delinquent may be complying with the norms set up by his delinquent companions is an excellent example of confused thinking and the need for multidisciplinary training in the field of mental health. It is true that in sociology we find the concept "norm," but this concept has no relation to

“normal" vs. “pathological” as applied in the psychiatric field. The problem of “higher” and “lower” ego organization, it seems, falls into this same confused form of thinking, based on the idea that the brain has an evolutionary history that is reflected in its structure.

The structural theory in psychoanalysis contains the concept of “higher” and “lower” brain layers in the developmental sense in applying this concept to the organization of the three agencies of the mind. Kernberg (1975, p. 7) uses this theory, saying that he has attempted to build on the work of Menninger a model that will “improve our understanding of the specific archaic levels of defensive organization in patients with borderline personality organizations.” It is on this basis that Kernberg has suggested his “classification,” placing borderline conditions on a “lower level” than the “narcissistic disorders.” Lewis Wolberg (1977, pp. 412-414) also constructed a classification of defense. In his scheme the more destructive forms of acting out were assigned the areas where fantasy tended toward delusion. As I have often said, it appears that these defenses are related to the degree of trauma and stress within the family and experienced by a particular individual and to the kind of identifications he or she has been forced to develop.

Defense vs. Developmental Theory

The dynamics of identification and the defenses surrounding this major

defense are much more important in understanding the various syndromes than any theory that uses the concept of a developmental system. I am reminded of Geleerd who wrote, "In order not to lose the parents' love, the child adopts their repressions, denials, reaction formations, etc. Thus only by taking over a considerable part of his parents' neurotic ways can he join the human community" (1965, p. 122).

Some defenses appear in the infant at birth, and so they do indeed have a genetic origin. It is the social situation, however, that creates anxiety in the child and stimulates mental elaborations and overlays in the use of the basic defenses. Perhaps the fear response that develops between 8 and 12 months is, in fact, a defense of genetic origin that has a self-preservative effect. Such a postulation does not discount the relation between the structure of the society and the rate of suicide. As we have said, many studies indicate a functional relationship between social dynamics and mental problems. Henle (1972) and Brenner (1973) have emphasized the relationship between symptoms, stress, and social situations.

The studies of Jackson, Weakland, Johnson and others have accented what has been known for some time—namely, *the family is the seat of the onset and stimulation of a great deal of neurotic and psychotic behavior.* A social system theory is important in understanding the derivation and dynamics of emotional disorders, particularly as social dynamics are related

to identifications set up in the family. It is the conceptualization that we see reflected in the patient's repetitive dreams and fantasies. The history of the child is delineated by the associations and these may be connected with the phenomenon called the Zeigarnik effect (see page 153). *Identification* is a *group-determined phenomenon*; thus we must learn something of the dynamics of groups. For example, the kind of stimulation in life that the infant receives is thought to influence future behavior (Caplan, 1973, pp. 87-97); but whatever the stimulation, the factors of intelligence, learning, reality testing, memory, and so forth, are not affected in the sense that they can be eliminated or prevented from operation. They are genetically determined. The fact that learning may be disrupted by anxiety does not mean that the learning process has been destroyed or damaged. Those theorists who feel that there are lacunae in learning or that there are gaps in understanding in the borderline patient are, I believe, in error.

A reevaluation of the first years of life, in view of the various theories concerning the borderline patient is in order. In the light of modem knowledge we must take a second look at the concepts of narcissism, fixation, primary process, and other speculative concepts such as the ego and the id. The concept of heredity was a primary factor in Freud's evaluation of the early phases of life, and yet it is Freud's theory that has influenced many theorists to look at the family as the source of stress and neurosis. The environment can be a primary source of stress for parents and children alike,

and this fact affects all classes of people in their relations with others. Parents of borderline patients who themselves have been traumatized by their own parents react with aggression, depression, withdrawal, and other defenses when they feel anxious. And they use their children in the interest of their own defenses (this is the basis of neurotic identification I, but their learning capacities have not been destroyed.

It seems to me that the concept of the "cumulative trauma" due to frustrating experiences with parents is the basis for a more reasonable hypothesis of emotional disorder than defective instinct derivatives with the birth trauma as the prototype for anxiety leading to a weak ego with no boundaries. Stress is a factor in body response (and it may be that untoward chemical reactions in the body systems can be stimulated by various degrees of stress and can effect not only the physical systems but the neuro-physiological systems as well). Spitz and Cobliner (1965, p. 139) have posited a "strain trauma" and "chronic traumata." Selye (1956) has given us data regarding stress. Freud (1926, 20:133, 138) assumed an automatic trauma at the beginning of each regular phase of development. Later he emphasized separation from the mother as a source of early anxiety. The cumulative effect of development itself, according to Freud, was a basis for anxiety, given a defective heredity. Eventually, he considered traumatic events and experiences with parents as a source of reviving the original anxiety.

Spitz wrote that he observed “identification with the aggressor” in a child of 16 months (Spitz and Cobliner, 1965, pp. 186-187). This would mean, I believe, that the 16-month-old child had already adapted to a sadomasochistic mode of life in the family. One would have to say, however, that this particular child does not have a neurosis at the age of 16 months, but if the child were to develop a neurosis in later life, we could assume that the symptoms of identification with the aggressor persisted and had a major effect in the life style of this particular individual. In other words, the child continued to be in a stressful situation up to the point where the neurosis (the defense) was organized and then found his own stressful situation in order to perpetuate the neurotic defenses. If we substitute the concept of “identification with the aggressor” for the idea of “fixation” (which is a nebulous concept at best that creates confusion and misunderstanding in psychoanalytic theory), then with the idea of “cumulative trauma,” and the recognition that the traumas require the gradual development of a defensive system, we may be on the road to more clarity in our concepts. Freud’s idea of the dynamics of development, however, was that identification takes place automatically as a function of the learning process and that identification is a prime dynamic in the organization of the ego and the secondary process beginning in the stage of “secondary narcissism." Identification, along with idealization of the parents and the formation out of these of an ego ideal, was the basis for the organization of a superego, which was an “internalization” of

social experience related to the oedipal problem. The oedipal problem was the stimulus for the defense of repression. The concept of "internalization" is the psychoanalytic explanation of learning from social experience.

If we were to think in terms of "cumulative trauma" as the consequence of the parents' need to use the child in the service of the parents' projective defenses, as I suggested in 1960 and again in 1973, then we would have to consider identifications with parents (the aggressors) as a function of the parents' neurotic needs and their active use of the child in maintaining their neurotic (or psychotic) homoestasis. We would recognize that identifications develop slowly over time in the social milieu of the family as a resolution of the anxiety created in the relations with parents. The sexual line of development may proceed in somewhat the way that Freud described. but the whole social system cannot be explained on the basis of the oedipal problem. But early phases of infant development we understand today do not evolve quite as Freud conceived of them. Freud was often willing to say that he might be wrong, but when a colleague argued with him about his ideas, he was relentless in his defense. In discussing how phylogenesis might repeat itself in ontogeny, Freud made many questionable statements although he understood only too well that the environment, over the eons, had a role in influencing genetic or hereditary factors. The interplay between environment and the individual on the biological and psychological levels was recognized by Freud, but he still clung to the idea that heredity was more important in

the everyday existence of each individual. Freud pointed up many bipolar phenomena that would automatically create friction or problems that had to be resolved; the individual and society, the ego and the id, the ego and the superego, male and female, ego libido and object libido, parents and children, and on and on.

Adelaide Johnson and her associates appear to have documented the environmental theory and the role of parents in creating the defense of identification with the aggressor as a fundamental dynamic in the neuroses and the psychoses. In my opinion, this is an important dynamic of borderline conditions. A brief statement of the application of her theory to antisocial behavior is found in a paper she wrote with Szurek (Szurek 5 Johnson, 1932):

> Our thesis is that the parents' unwitting sanction or indirect encouragement is a major cause of the specific stimulus for such anti-social behavior as fire-setting, stealing, truancy. By means of study and concomitant treatment of parents as well as of the child involved in anti-social behavior, it becomes unmistakably evident that one or occasionally both parents derive unconscious vicarious gratification of their own poorly integrated forbidden impulses in unwittingly sanctioning and fostering such behavior in the child. In every patient brought for treatment in whom simultaneous study of the parents was possible, the child's defect in conscience was traceable to a like defect in the parents.

This paper was written the same year as my first paper on the borderline patient in which I was coming to a conclusion that was similar concerning all kinds of acting out—antisocial, self-destructive, delinquent,

nondelinquent. It took me another eight years to realize that it was an interlocking neurosis that was involved between the parents and that in fact the parents were using their children as projective objects in the service of their own defenses (Wolberg, A., 1960, pp. 179-180).[13]

Winnicott and followers of Sullivan use the concept “not me” or the “false self” in relation to what the early analysts called the “pathological introject” and the “imagoes,” alluding to what I would see as “identification with the aggressor.” It is in this sense that identification is the consequence of a group process, and is defensive, rather than that identification is due to an innate factor that automatically makes itself known at a given time in the genetically determined unfolding of development. It is this identification defense that creates the bedrock for the sadomasochistic system that is the dynamic responsible for projective identification in the borderline patient (Wolberg, A., 1973; also 1977). To think of sadomasochism as deriving automatically from an early phase of infancy where voyeurism, exhibitionism, and other such phenomena are present is to project onto infancy characteristics that can be but symptoms of certain neurotic adults or adolescents. Identification is not a manifestation of the “innate schedule." Neither is sadomasochism in my opinion. The two, however, are related in the dynamics of the borderline patient. Now we may say that identification is reflected in an “internalization,” and becomes possible through learning, i.e., through a combination of learning, memory, the ability to imitate, and so

forth. But identification becomes viable because of the capacity of the individual to focus on certain types of behavior, to communicate with parents on verbal and nonverbal levels and on a host of other variables, such as the ability to inhibit certain creative or other normal forms of impulses. Identification depends upon relations with objects, but *the capacity to identify* is a function of several factors that are probably genetically determined. My concept of the borderline patient, unlike that of Kernberg, is that his *emotional disorder* is a *product of identification.* Over a long period in face of much resistance on the part of the child, the parent finally imposes the identification behavior (Wolberg. A., 1973).

There are numerous manifestations of the "innate schedule," including such phenomena as the "excitement" (the emotion) evident in the infant that accompanies new learning. (Is this like Freud's concept of libidinalization of the object a pleasant feeling or energy that Freud called "sexual" in learning? or communication via sounds and gestures?) Probably learning itself and memory have a relationship to the genetic code since these seem to be present at birth (see *Science News*, 1977, for new information on "The Brain and Emotions"). We know now that the brain and the heart apparently are organs that function early in fetal life. The brain is obviously needed in the unfolding of neural and physical fetal development and has a relation to learning even in prenatal existence. What the psychoanalyst calls "internalization" apparently has its origin in prenatal life since the fetus

begins to be responsive to external events perhaps during the eighth and ninth months and then learning in relation to objects, or at least reactions to the actions of objects begins. (The fetus will move if a light clapping goes on outside near the mother.)

Usually the definition of "internalization" corresponds to what is meant by *learning in communication with people and objects.* Why the psychoanalyst must create a special definition concerning learning is not clear. The psychoanalytic definition of "internalization" includes the concept that *incorporation, introjection*, and *identification* are object-related mechanisms. There are many authorities who believe that there are no such mechanisms as incorporation and introjection, these ideas being based on Freud's and Ferenczi's notions in relation to the concept of "introjected object." They dispute the idea that the oral phase of development has certain atavistic phenomena based on certain ancient tribal practices which can be recreated in regression. This, I would say, is one of the erroneous concepts that has crept into the consideration of borderline dynamics and is now posed by many theorists. Many faulty concepts regarding borderline pathology result as a consequence of the use of Freud's developmental theory, particularly his ideas of primary and secondary narcissism.

The concept of learning and memory in infancy has been confusing until comparatively recently. It is now rather clear that even the day-old infant has

begun learning in earnest. Memory is present shortly after birth, and probably before, and seems definitely to have been established in depth by the age of 3 months.

The studies of Szurek and Johnson (1952, 1954) and others have shown that there is a direct relationship between identification with the aggressor, fantasy and internalization, i.e., identification and acting out. I would say that neurotic fantasy is a representation in the mind of the identification process and the conflicts associated with these identifications (disguised) rather than a reflection of some kind of developmental phenomenon, or some primal "fantasmagoria." Fantasy is a disguised way of representing the interpersonal implications of the identifications, and this kind of fantasy must be distinguished from the kind of thinking that is related to problem solving and creative thought. De Casper (1979) has reported an experiment that he did with a newborn several hours after birth. It appears that the infant could cooperate with him, or at least there was communication between the infant and the experimenter to the effect that the infant accomplished the task of discriminating between the mother's voice and the voice of another person. From what I have gleaned there appears to be an innate capacity for discrimination in the infant—i.e., the ability to distinguish "pleasant" and "unpleasant"—and, together with the innate capacity to "perceive" with two or more of the senses, the infant is capable of cross-modal integration, a necessary process in learning. Can we say, then, that the infant engages in

creative thought as he learns in this early stage of his postnatal existence? It seems likely that this kind of performance is more complicated than reflex response and thus could be called cognitive activity based on interpersonal experience.

Green (1977) has written about what he calls "the creation of neoreality" in the psychoses (and in borderline conditions), saying that it is analogous to the neurotic world of fantasy. One can certainly agree with this so long as we use Freud's early definition of fantasy (Wolberg, A., 1973, p. 15). One could say that "neo-reality" means "fantasy" and thus can mean fantasy expressed in hallucinations and delusions, all the result of a conflict concerning reality. Freud's formula seems to say that neurotic defenses are not due to conflicts over reality but to "intrapsychic conflict." I have proposed the primacy of identification fantasies in emotional problems. The "neo-reality" that Green speaks of is in fact an *identification fantasy*, a loosely defined delusional system in the borderline, paranoidlike but not systematized as in schizophrenia (Wolberg, A., 1952). Green uses a "higher" and "lower" concept in his theory, which means a distinction for those terms between secondary and primary thought processes.

Freud wrote (1924) that "neurosis does not disavow the reality, it only ignores it; psychosis disavows it and tries to replace it." In this essay, however, Freud concedes that in the neuroses, as in the psychoses, the

fantasy serves as a respite from reality. Thus Freud never quite succeeds in making a difference in this respect between the neuroses and the psychoses. He did say that the real difference is that in the psychoses the ego is subject to modifications of a different quality. Disavowal and the remaking of reality in the psychoses are contrasted with repression and fantasy in the neuroses, although is it admitted at the end that in both neuroses and psychoses a denial of reality exists, and thus repression would have to be present.

If we understand that hallucination and delusion are forms of the identification fantasy expressed in the context of projective identification (a remaking of reality), then we can see that a certain kind of mental organization representing reality persists in the psychotic, even in the midst of what has been called an inability to perceive reality. Freud remarked that the individual can correct a delusion in a dream (see Freud, S.E., 1938, 23:201-202), a feat that may be possible because the delusion in any case represents reality in a disguised form. The “false self,” “neo-reality,” or simply the “bad self" together with the “remaking of reality” are phrases that represent what I would call identification fantasies in various forms. They are also defenses. Associations to these fantasies and their dynamics reveal the patterns of interaction in the family that were traumatic. They are, therefore, repetitive and representative of the conflict that has been resolved in an unsatisfactory way and therefore might be related to unfinished tasks (i.e., the Zeigarnick effect is operative).

Green (1969, 1977) has elaborated a more complicated definition of "splitting" to explain the "remaking of reality" and denial than that of Kernberg. Utilizing Freud's concepts of the developmental differences between hysterical and hypochondriacal symptoms (this is a "higher" and "lower" level concept according to Freud's theory of sexual development), he has an explanation of three types of symptoms seen in the borderline that he feels have a relationship to "splitting": (1) that of denying pleasurable experience, i.e., the sensations or feeling accompanying the particular experiences are denied, (2) hypochondriacal ideas; and (3) the symptom of acting out. It appears that all of these phenomena might be considered to be hysterical-like in nature and that there are *fantasies* connected with each type of symptom—those connected with hypochondriacal problems being fantasies that tend more toward delusion. There is undoubtedly a difference between hypochondriacal symptoms where physical illness does not exist and psychosomatic symptoms where there is real illness, such as stomach ulcer or forms of colitis. Green discusses psychosomatic symptoms and seems to find, dynamically speaking, a likeness between acting out and such symptoms.

Green writes that it would be erroneous to think that splitting occurs only or mainly during the separation of the "external" from the "internal." In fact, splitting, he insists, also occurs (perhaps even predominantly) between "psyche" and "soma," thus consequently between "bodily" sensations" and

“affects.” This dissociation takes subtle forms as in the isolation process that disjoins “affect representations” and “thought" (see the discussion of the “isolating process” on pp. 230-231. Motor reactions (which include acting out) may also be split off from the “psychic world.’’ Two frontiers established by splitting are “between the somatic and the libidinal body, on the one side, and between psychical reality and external reality involving the libidinal body and action, on the other." As a consequence, “we may assume that the split-off soma will intrude into the psychic sphere in the form of a psychosomatic symptom." Green sees differences in the defenses between psychosomatic symptoms and those found in conversion hysteria and the hypochondrias; thus whereas conversion symptoms are built in a “symbolic fashion" and are related to the libidinal body la higher level operation), psychosomatic symptoms are not symbolic but are simply somatic manifestations “loaded with pure aggression.” He then says that hypochondriacal symptoms, on the other hand, are “painful representations of somatic organs filled with narcissistic delibidinalized destructive libido." One may assume, contends Green, that there is also a lack of symbolization in acting out. Insofar as it is a symptom, acting out may have a symbolic meaning for the analyst but none from the patient’s point of view, he being blind to its possible meaning. It is not “linked” to anything other than its manifest rationalized content. (We may ask ourselves these questions: Is not rationalization a defense? A lie? And is not rationalization a defense against a reality that the patient “knows” exists?

Is not rationalization an expression of aggression? Are not rationalization and lying connected with fantasies?) According to Green, the difference between splitting and repression is that in repression the psychic energy is bound, links are intact and combined with other representatives of affects lid derivatives), the original items in the associative link are replace by others, but the "linking function" is only transformed—not altered; in splitting, the links are destroyed or so impaired that only by intensive effort can the analyst *guess* what they would have been. Thus, Green "strongly objects" to the notion that borderline patients engage in primary-process thinking. This idea of linkages and the lack of them is used also by Rey (1975) in relation to a theory of group therapy.

Green agrees with Kernberg, who contends that the borderline patient's acting out is based on a raw discharge of instinctual energy rather than on any form of identification. In my opinion identifications can be discovered in the borderline patient in many ways, not the least of which is to have an interview with the family. In therapy sessions one can discern these links in the patient's productions by "listening with the third ear." The fact that the links are denied or disavowed does not mean that the patient does not tell us of them. The projective techniques that I have recommended for use with the borderline patient are a means of relating to the denied aspects of the patient's problem by discussing the dynamics of the "others" with whom the patient is in contact and with whom he is identified. My patient Sonia in

sessions with me began to recognize her identifications with the people in her dreams and the particular characteristics of her own that are identical to those of the people with whom she is associated socially (see pp. 258-261) and who appeared in these dreams.

Green states that splitting is a force by which something is excluded—in fact, is disallowed and becomes unworkable or unthinkable. He does point out (correctly, I believe, but inconsistently with his theory) that there is a “return of the repressed" in splitting, with the difference that it will have an “intrusive persecutory quality” by way of projective identification. One would have to disagree that in the process of disavowal associative links are not operative or present since they are conceptualized and retained in the delusions and the hallucinations (which, as I have said, are merely projected forms of the identification fantasies) by way of projective identification. The identification fantasies activate acting-out behavior when current situations stir up feelings that are similar to those that existed in traumatic situations with parents and others in the past with whom the patient was associated; thus there are important links between mind and body action in the here and now. In impotency or frigidity, for example, we find a tendency to disavowal of pleasurable sexual contact. The denial of pleasure from work success is a symptom of the borderline’s disavowal mechanism. The fantasies can be elicited, and Rosner (1969) has suggested how the associative process works in these cases. For example, L.R. Wolberg (1945, 1st ed.; 1964, 2nd ed.) in the

case of Johann R. demonstrated by hypnosis that the “links” are obviously there. Acting out is, indeed, a symptom and a return of the repressed.

Green cites as important to the understanding of the borderline Bouvet's (1967) description of the “pregenital structures,” especially his “depersonalization neurosis.” He writes that Freud assumed the basic function of the instinct in the psychic field in relation to objects to be the lowering of unpleasurable tension. The British school assumes that the function of the instinct is “growth” and Green assumes that the basic function is “representation.”

Does this term “representation” refer to the process of “internalization”? And are these the processes by which the mind forms both an image and an idea of an object? If so, then this is related both to learning and the organization of defensive fantasies, which like lying can be considered a manifestation of the creative process used as a defense, but for hostile purposes. It seems to me that, properly defined, the function of the instinct, if one uses the word to mean genetic factors, can have a relation to the lowering of tension and to adaptation and growth.

“Representation” as I understand it is a mental process, an aspect of perception, learning, and the “processing of information.” It relates to the effects of experience in the world. The concept is used in relation to the

secondary process as opposed to the primary process when “representational reality” is distinguished from “psychic reality.” The concepts primary process and psychic reality, however, if these refer to fantasy, cannot describe a nonrepresentational or nonsymbolic substantiality, for fantasy is in essence symbolization. As our information stands today, there is no nonrepresentational phase of development in the mental or cognitive life, since the infant sees patterns as wholes from the first few days of life. Piaget’s nonrepresentational stage does not seem to exist, but there may be a pre-symbolization period. The infant in his perceptions outlines an integrated picture of the object with his eyes, and he “conditions” and learns very rapidly with experience, associating “good” and “bad" or “pleasant” and “unpleasant” with situations and with objects. We know that perception is part of the process of representation. The latter is actually an integrative capacity, which, in turn, is one of the “givens” of the individual at birth. It is my impression that Freud wrote that the basic function of mind is adaptation and survival, a self-preservation motif. When Freud talked of an “innate schedule,” however, he referred to the periods of development according to his developmental scheme, i.e., oral, anal, phallic, oedipal, . . ., and to the appearance of the sadomasochistic instincts at these developmental stages and their effects rather than to an unfolding of certain types of behaviors like smiling, gesturing, the 8-to-12-month fear reaction, imitation, and the like that are obviously behaviors that help in self-preservation.

Winnicott (1953a, b; 1965) according to Green, in his explanations of borderline conditions, has provided us with the greatest insight into emotional development in his concepts of "primary maternal concern" and "holding," shifting the attention from the overall "internal object" (Klein) to the role of the external object. (Fairbairn was the English psychoanalyst who introduced this idea.) Adler, Sullivan, Fromm, Jackson, and Horney had similar concepts. As I see it, a shift in emphasis to the object means a shift to the importance of family dynamics in emotional problems, which I stressed in my 1952 paper. It was not until 1953, however, that I began to realize the significance of an interlocking defensive process between parents as the possible stimulus for the development of the identification role and a primary basis for the beginning of an emotional problem in children. Finally, in my 1960 paper I tried to discuss these dynamics. I felt that the important research by Szurek (1942) and Johnson (1949) leads to the conclusion that parents play a major part in the organization of emotional disorders in their children. I proposed that it was due to their need to utilize their children in the service of defense that this occurred. These authors interpreted their findings in the context of the structural theory, emphasizing the impact on superego functions. Jackson's research, however, over a period of several years emphasized the concept of "family homeostasis" and measures taken by parents to control their anxieties so as to perpetuate their neurotic adjustment, and it is this "systems concept" that has proved most useful in

understanding the family dynamics and the relation of neurotic and psychotic defenses in family members to the organization of identification behavior. (For a complete bibliography of Jackson's work see *Group Therapy: An Overview,* 1977).

Green (1977) credits Winnicott (1958) with emphasizing the interplay of the "external" and "internal" and "of the intermediate" or the "failure to create it." In his view Winnicott is concerned with the "fate of symbolism." the functional value of the "transitional field," and particularly "transitional phenomena" in borderline cases. Green contends that Winnicott would say, "The setting and the analyst do not represent the mother; *they are the mother*" (present author's italics). It is not clear as to the role Winnicott means the therapist to play. As Kohut suggests, must the therapist act as a mother, a corrective person (the good mother that the patient did not have) so that the defects that occurred in the ego or "self" from poor mothering can be made up? Or must the therapist in playing the role of mother actually *be* the mother? Or, does he mean that the patient has the delusion that the therapist *is* the mother or that the therapist has the delusion that *he* is the mother?

Modell (1963, 1968, 1975) has discussed Winnicott's concept of the transitional object and has compared the borderline's transference response to the therapist as similar to the infant's response to a teddy bear or a blanket.

As part of this reasoning, Modell speculated that the borderline has difficulty in asking for help because he cannot tolerate refusal without developing hostile fantasies and fears of abandonment. In order not to have such feelings and fantasies, he does not ask the therapist for anything. Modell has made an important point in discussing the patient's pattern of "not asking," a response that is transferential due, I believe, to the rejecting pattern of the parents toward the child. The patient asks and asks and asks. It is only when rejection is forthcoming that he stops asking, recognizing that it is futile. He does this also so that he can have a certain amount of security and not be entirely rejected or abandoned. He fears the retaliatory hostility if he persists in asking for his rights. The transference feeling is that he will be rejected by the therapist—or by anyone from whom he may ask. This is, of course, a masochistic pattern. On the other hand, this patient does have a way of asking even when the request is not verbalized and he resists help even when seeking it. He is the help-rejecting patient who seems to take pleasure in frustrating the people from whom he is asking help and making *them* feel impotent. He seems to be showing hostility and revenge patterns with this masochistic stance. Modell said that the patient does recognize the therapist as existing separately from himself, but, unlike the neurotic, the borderline does not have the capacity to recognize that the attributes assigned to the transitional object (the equivalent of the blanket) are projections (or, rather, "perceptions") emanating from within himself. (I believe that the patient may

recognize this, but he does not always take the recognition into account, i.e., he denies what he knows.)

Winnicott thought of the blanket as a *protective shield* and an object used both lovingly and in a hostile manner (the child mutilates the blanket and loves it, two opposites—Eros and Thanatos), the expectation being that the blanket must survive both kinds of usage. (Is this another way of talking of sadomasochism?) The blanket, Winnicott avowed, was something that possessed characteristics of its own, such as warmth and texture. Winnicott's idea that the child needs warmth, acceptance, understanding, love, and other forms of stimulation is certainly valid. I think we must understand the patients' aggression, however, in the light of frustration and the cutting off of feeling as a manifestation of the identifications with parental figures. Winnicott's idea is that the blanket or the teddy bear takes the place of the mother, and like the mother (according to Melanie Klein) it must withstand love and hate.

Melanie Klein (1946) conceived of all mothers as being in a tenuous position with their infants—being the object of love in some instances and the object of hostility at other times. If the mother could survive the ambivalent usage, then the child had the opportunity to be healthy, but if she had difficulty, this did not bode well for the child. Fintzy (1971), Mahler, Pine, and Bergman (1975), and Volkan (1976) use the idea that the transitional object

is related to a phase of development in the child's separation from the mother. Rey (1975) has suggested that in group therapy the members serve the function of transitional objects who provide the "missing links" (an idea similar to Green's) or the missing "representations" that did not occur in the mind at appropriate periods in the patient's development due to poor mothering. This is a lacunae theory.

Winnicott writes about the "false self" or a "not me" as an "overdemanding adaptation" to the "need-supplying object." (As I said before, I would also call the "false self" an "identification with the aggressor.") Winnicott's later concepts of *"noncommunication*," *"void" "emptiness*," "the *gap."* and the "impossibility of creating out of these another form of reunion with the object regardless of whether its energic aspect is wholly or only partly traceable to the instinctual drives once formed" are really important, in Green's estimation. Here we are unfortunately presented with the same controversy as that between Kernberg and Kohut. Does Winnicott think of "the void" and "emptiness" as defenses of the ego and the "gap" as a developmental defect? As a matter of act, "emptiness," "void," "blank," "apathy" are phrases that have a similar connotation to "life has no meaning." All are evidences of depression in borderline patients, as I view it, a depression that is often overlooked or missed by many therapists. However, as we have stated, in the context of "higher" and "lower" forms of development (preoedipal and oedipal phases) the borderline does not,

according to Kernberg, have depression (a higher order of reaction associated with guilt and the oedipal problem), but experiences only apathy (a lower form of expression) and has *envy* rather than *guilt feelings.* Does the "gap" refer to "missing links" in the ego? To depression? Or to some other kind of phenomenon?

Green insists the return of the split-off elements (i.e., return of the repressed) is accompanied by signal anxiety and emotion, which is described by Freud (1926, 1927) as "helplessness" (*hilfosigkeit*), by Klein (1946) as "annihilation," by Winnicott (1958) as "disintegration" or "agonies," by Bion (1970) as "nameless dread," and by Green (1969) as "blankness." Apparently, these feelings are to be distinguished from depression, as Kernberg's theory implies. Kernberg speaks of the "dread of loneliness," which I take to be a depressive attitude related to fears of self destructive impulses. Summing up modern research, Caplan (1973, p. 92) tells us that at the age of 3 months the "higher brain" takes control. Does this mean that the "higher and "lower" postulations of psychoanalytic theory with respect to ego development and the concepts of primary and secondary process are in error? One can agree that the "return of the repressed" is accompanied by anxiety; in fact, in my opinion, it is anxiety that stimulates the return of the repressed—anxiety related to anger or fear or both. In Chapter 5 we shall see that many investigators feel that the infant of several hours of age engages in "higher brain activity."

Can we say that this “higher” and “lower” brain activity has something to do with ego development? Can we say that Klein’s theory of early stages, i.e., the schizoid stage and the depressive stage, has something to do with the development of the ego? What has this to do with the adult state of depression? Does depression have a relation to the oedipal stage? Does the preoedipal stage mean that there is no true relation to objects and that, therefore, there is no guilt and thus there can be no depression? Could Klein have thought that depression was regression back to the earlier stages or was there a kind of in-limbo stage, one that vacillates between the schizoid stage and the depressive stage with no real footing in either? Freudian theory has been interpreted to mean that there is not guilt in the preoedipal stage and that, therefore, there could be no depression. These theories hinge upon the idea that idealization is a normal step in the advance to the oedipal period. Most theorists today say that the borderline has not reached that period in ego development where idealization of the object has solidified so that the individual can go on to the next stage where guilt and repression are present. However, Caplan tells us of a “self” in the seventh month of life and the ability of the infant to distinguish between family members. The mother becomes more important than others (Caplan, 1973, p. 93), yet the child shows preferences for other people too. Does this mean that by 3 months the supposed autism or the narcissism is broken and the object is valued for its own sake?

Incidentally, in the *Archives of General Psychiatry* relative to the drug treatment of borderline patients there is an article on depression, "Low-dose Neuroleptic Regimens" (Brinkley et al, 1979), one of the few double-blind studies done to indicate that antidepressant drugs, notably Tofranil and Nardil, were helpful in borderline cases. Brinkley found that low doses of such drugs as Thorazine and the like can be useful too. I have found that some borderline patients reject helpful drugs for the relief of depression and use the more harmful ones such as the amphetamine energizers, alcohol and others. To an extent, this is due to their masochism and their negativistic attitudes toward authority—and perhaps their hidden suicidal aims. There may be a relation between depression and masochism. A true idealization would mean that the depressive attitude (Klein) would have given way, and there would be no persecutory objects, as there are in depression.

It is the schizophrenic patient who so often has the "dead look"—"the void." This usually indicates that the individual has withdrawn into fantasy and is using the defense of detachment. But detachment and depression are not quite the same, although perhaps they are related. Detachment is a process of withdrawal into fantasy, a defense against feelings of aggression toward others. Depression is, in my opinion, related also to aggression, but the aggression is self-destructive in the face of feelings of misuse by others as well as rage at the latter. The schizophrenic is also self-destructive, but he has a defense of withdrawal that is somewhat different from that of the

depressive in that he is likely to have persecutory hallucinations while the depressed person may have paranoid feelings but is less likely to have a hallucinatory defense. In any case, the depression in the borderline is not so severe as the endogenous depressive or the schizophrenic depression. The depression in the borderline is chronic—but it is of a less severe nature.

It is difficult to accept a theory that relates mental and emotional disorders to "fixations" at infantile levels developed as a result of distortion over limited periods of time during particular early developmental phases. I believe that it is much more realistic to accept that the kind of experience the child has in the family *over time* is the most important factor in the development of personality needs and defenses. Defenses can serve masochistic needs; thus they do not always safeguard the individual against self-destruction. Detachment is the distancing mechanism that accompanies not only depression but other defenses as well. Depression should probably be thought of as a defense since it is a mood or feeling, one associated with fantasies specifically of anger, revenge, and low self-esteem and with compensatory feelings of grandiosity, which are a function of the revenge feelings. Depression often derives from the original feeling of being abused, used, and rejected by parental figures. Both schizophrenics and borderlines have this experience with its accompanying feeling of abuse and misuse. I believe that it is this depressive mechanism (with a paranoid tinge, i.e., a projection to protect the patient's identifications with the rejecting parents)

that is present in the pattern Modell has described.

Green considers Winnicott "the analyst of the borderline." He values the Winnicott concept of the "false self" built, as he says, "not on the patient's real experiences" but on the "compliance to the mother's image of her child." Since the mother's "image of her child" is a projection of the mother's identification with her own parents, which she wishes to deny, and the mother is *active* through her punishments and rewards in seeing that her child "complies," in my opinion this, indeed, is a real experience for the child. The eventual accepting of the identification, in spite of protests, is one of the bases of what Spitz (1965, p. 139) and others (Furst, 1967, p. 32; Kris, 1956, pp. 72-73) have called the "cumulative trauma," which promotes the neurosis and is the essence of the "false self" organization. The child does not automatically "comply" with the mother's image of her child. He resists. Thus the *identification* (for me the appropriate terminology for what Winnicott calls the "false self") develops over a long period of time. One needs to employ role theory to depict the dynamics of this identification process (Wolberg, A., 1960, 1977).

The "image" that Winnicott speaks of, to my way of thinking, is a certain fantasy that contains a specific kind of role that the parents project, the father being involved in such projections as well as the mother. There is punishment and reward in the parents' insistence on these roles, and *this is a continuous*

process—not simply in the child's infancy but over the years as the parents and the child live together. The role is finally integrated by the child, and the process is an "identification with the aggressor." In turn, these identifications when acted out are aspects of the interlocking defensive system in the family. Rinsley (1976, 1978) speaks of this "image" as being one of the mother's own parents or a sibling, a projection she used to defend against her feelings of abandonment. I believe that Freud's "loss of object" as the "danger" in depression is similar to these "feelings of abandonment" (by the parent) that Rinsley and others mention. The basic problem, however, is not only a fear of abandonment. Rather, it is a realization by the child that he is *rejected as a person in his own right*, a realization that is the basis of his denial, detachment, depression, and rage and his consequent neurotic need for a sadomasochistic relationship. The picture is complicated by the fact that he must comply with the projected role, thus the two-edged function of depression as a defense against aggression toward others and toward the self. This defense does not prevent the expression of aggression, but it does inhibit the full expression of anger and revenge and helps contain the fear of the destructiveness of the parents, both of whom are involved in the projective use of the child. The child's deepest fear, I feel, is the fear of annihilation as a consequence of parental destructiveness.

It is the need to be related to a sadomasochistic object, (the object of identification) that creates the fear of "loss of the object" and what has been

called the “fear of abandonment.” (“If I don't do what my parents want they will abandon me, or send me away. ”I The identification, as Rank suggested, is an insurance against being destroyed, an insurance against death that does not always work in view of the numbers of infants and youngsters that come into the category of “battered children.” On the parents' parts, the expectation of compliance is there, so long as the individual remains with his family. He perpetuates his compliance after he leaves home by finding someone with whom to relate who will interact in such a way as to provide the interlocking defensive relationship he had at home. If we must speak of a “punitive superego” (I prefer to use the concept “identification with the aggressor"), then we should define this as a compliance with the demands of the father’s and mother’s needs of identifications with them, which they have actively fostered due to their own anxieties. The “false self” is the internalization of the identification that motivates the individual to act against his best interest in favor of reducing the anxieties of his parents through particular behaviors. It is this compliance with the role demand of the parents for “particular behavior" that creates the further need for denial and stimulates the patient’s self-contempt as he slowly “gives in” to the role. His self-contempt is compounded as he gradually, through identification, becomes in some respect like the parents, using patterns he both loathes and fears. He would rather give and receive love. It is this *giving in* and *becoming like the parent* and the wish that things were different—and the almost delusional thought that the

parents will change at some time rather than accepting the fact that it is the child himself who must change—that are the basis of the borderline patient's denials and disavowals.

Freud (1931) mentioned the *fear of being killed by the mother* as a dynamic in females, while in males there is present *the desire to kill the father* (1921). “In Family Romances” (1909) Freud noted the child's wish to be in another situation—a member of a different family. In the essay “Female Sexuality” (1931) Freud spoke of love relations that are inhibited in their aims, the child’s feeling that the mother did not “give" enough, castration fear. In “Civilization and Its Discontents” (1929-1930) he wrote of the dynamics of fear, guilt, and conscience, of aggression, but he did not put these all together in the context of sadomasochism. He pictured these in the light of the libido theory (sexuality) and the resolution or lack of resolution of the Oedipus complex, as well as the idea that in the end man will destroy himself and his civilization by his own aggression, which he will never learn to contain. Freud would never quite come to the conclusion that both the mother and the father were bound together in a neurotic contract, or defensive alliance, to maintain homeostasis or equilibrium and that the father too had excessive amounts of aggression, which the child feared.

In treatment the patient hesitates to step out of the sadomasochistic role in order to change because he has been made to feel responsible for the

mental health of his parents by accepting the identification. On one level he would rather remain ill than to hurt them and experience the guilt he might feel by causing them to develop a psychosis or "go to pieces," but on another level he expresses his aggression and hatred. The ambivalent attitude is a hindrance and a defense. The conflict over the parental behavior is unresolved—or is resolved through submission, which is an unsatisfactory state. The patient denies and clings to the denial that he is sadomasochistic, particularly that he is sadistic and destructive and that he expresses his pattern of revenge as a consequence of the rejections by his parents. He projects his aggression and utilizes others outside the family upon whom to vent some of his rage. He does express anger toward the parents, who invite it to a certain extent in order to assuage their own guilts.

Actually, in the family as the parents deny their active role in the maintenance of their neurotic equilibrium using the children as projective objects in the service of their defense, the child (under pressure from the parents! has no choice but to distort his concept of reality in the presence of these rigid authorities and to become something he does not wish to be. In the group process that occurs as identifications leading to neurosis slowly develop, there is in the denials a dynamic that takes place that is similar to what Asch (1951) demonstrated in some of his experiments (Wolberg, A.. 1968, p. 108). In his relations with parents the child eventually gets to the point where he will deny that the whole identification process has taken place

at all. He will isolate, or deny out of fear, those feelings and thoughts he had about his parents when they forced him into the identification. He wishes to deny too his knowledge that the identifications are destructive to him and that they interfere with his safety and an adequate life adjustment. (It is my thought that phobias are defenses against the patient's fears of annihilation and the fear is two-pronged: fear of the rage of others and fear of one's own counterrage directed both to others and to the self.)

There are times in the analysis of the borderline when there are mini psychotic episodes (Wolberg, A., 1952. p. 694) and also suicidal ideas. These occur when the reality of the relations with the parents breaks through into consciousness and the recognition takes hold that he. the patient, must step out of the sadomasochistic role if he is to be cured. At these times it is evident that the patient is not ready to suffer the anxiety of the initial phases of such change and that he is still clinging to the defenses of idealization and indecision (ambivalence). In seeking treatment, however, he has taken a positive step, but his denial mechanisms are extended to defend against this step. He is full of anxiety about seeking treatment, and he denies that this is positive behavior. He belittles the step and the therapist at the same time that he has great hopes that something positive will happen.

Winnicott says that in treatment the "building of potential space" opens new horizons. Apparently, "potential space" refers to the idea that the

therapist will be able to be less rigid than the parents; therefore, the patient will be encouraged to see more alternatives as his horizons expand under the impact of treatment. His “life space" will become greater, his movement more varied, his experience richer. (This may happen if the patient can overcome his guilt, fear, aggression, and ambivalence. I The social space widens, and the stimulation for the patient becomes greater from the point of view of new experience.

Countertransference

Winnicott points out the possibility of countertransference reactions in the therapist when working with the borderline patient. He says that the therapist is exposed to new ways of noticing his own reactions as a tool for comprehending the paradoxes of the borderline systems of thought. Much has been written of late of the therapist’s reactions to the borderline patient and the idea that countertransference helps us to understand the psychodynamics and psychotherapy of borderline states. I do not agree that countertransference is helpful; much of it stems from the therapist’s inability to comprehend the dynamics of the patient and the frustration that this evokes. If the therapist can correct his countertransference reaction, this is helpful. It may lead to insight about himself and the patient, but if he simply recognizes the countertransference feeling without being able to analyze it and to correct his position, then he will have gained nothing in the way of

clarity concerning himself or the patient.

Grinberg, who writes extensively on countertransference and understanding the borderline elaborates his theory of countertransference by describing the concept of projective identification in operation in the group treatment of borderline patients, using a combination of Freudian and Kleinian theory. He especially refers to what he calls “projective counteridentification.” He writes that normally (this is Kleinian theory) identification functions “practically from the very beginning of life, through what may be defined as the constant search for a balance between giving and receiving” (Grinberg. 1973). (Kernberg uses the concept of the patient's projection onto the therapist of “giving" and “ungiving" attitudes, which he says is a “mother transference" in borderline patients. One must realize, as has been repeatedly stressed in this volume, that this can also be a “father transference.")

Grinberg asserts that we should consider “the normal relations” that emerge from projective identification so as to take into account in therapy not only the subject’s projective identifications conditioned by his diverse fantasies and impulses, but also his primitive object's projective identifications. In addition to this, he insists, one must appraise the projective identifications of each member of the group. In Kleinian terms projective identification is a “normal" developmental, defensive mechanism that leads to

ego formation and the control of aggression.

Bion (1961) postulated a kind of psychotic bed (projective identification) upon which all individuals are originally grounded and which appears in the therapy group as a system of basic assumptions. These make up a combination of all of the psychotic beds of each of the group members. In a somewhat different view. Adler spoke of the patient's “private logic," meaning the fantasies, rationalization, distortions, and the like that the patient uses in his defenses. Bion has also a concept that is meant to describe the derivatives of the id or what Horney seems to have meant by certain patterns (tropisms?). Bion speaks of *dependency, fight-flight* and *pairing.* Horney, we will recall, spoke of moving toward, moving against, moving with, and so forth. Bion’s basic assumptions are “givens," and upon these givens he projects basic fantasies somewhat as Freud considered the id as a source of basic irrational fantasy. In group treatment, according to Bion. the members work through their “basic assumptions,” which are thought of a kind of “combined id" or “group id” leading to a more realistic outlook. The “basic assumptions,” we have said, are evident in fantasies and in trends of thought. This idea is an offshoot of Freud’s concept of the id and how it influences our lives in more important ways than reality dictates. Rangell (1955) quoted Glover as saying, “We are all larval psychotics and have been since the age of 2.”

Grinberg points out that presumably the analyst has worked through some of his own fantasies (reflections of his basic assumptions), but he avows the borderline patient's projections are such that they tend to lead the analyst into "projective counteridentification." Grinberg distinguishes between this process and other forms of countertransference, a distinction that is difficult to understand. According to Kleinian theory, we all have projective identifications, starting at birth, and this dynamic is inextricably involved in learning throughout our lives. New experiences always stimulate projective identification in the individual since this is the basic mechanism through which all experience is integrated. Klein's theory does with projective identification what Freud's did with identification. The assumptions are that identifications (and projective identification) are normal aspects of mental development and the stuff out of which the ego is formed. As I see it, both identification and projective identification are two sides of the same coin: they are defenses, the first of the neuroses and character disorders, where projection has not been so systematically employed, and the second of the borderlines and the psychoses, each associated with fantasies, and the more persistently projective defenses.

Grinberg (1973) states that "projective identifications lay the foundation for human communication," a premise that is questionable to say the least. There is an assumption in sociology and social psychology that group dynamics emerge from the communications, i.e., the interactions of

group members. However, communications related to projective identifications in group therapy would be considered, according to sociological theory, "self-oriented needs," and these would be impediments in (1) the problem solving process and (2) the development of norms both of which are the basic goals of group life. Foulkes (1948) seems to have been the only psychoanalytically oriented group therapist who stressed the importance and the function of *norms* as they develop in the group therapy process, thus assuming a conscious group problem-solving process. Foulkes pointed out that norms are aspects of group dynamics (see Wolberg, A., 1977), particularly in relation to the standards that the group members expect to meet. He understood such standards to be an essential factor in the treatment process with respect to analyzing neurotic behavior, this being the aim of the problem-solving process in treatment. Bion does say that the group meets to do something, that is, *to work*, and that there are two levels of operation, the *work level* and the *resistance level*, the latter more or less unconscious. The work group and the leader interact in the therapeutic alliance to enhance the "observing ego's monitoring of archaic assumptions." These are "unconscious, underlying, primitive part-object fantasy remnants persisting from distorted perceptions of early life." This is a different concept of fantasy than the one I use. I believe that fantasies begin in early life as a means of overcoming fear or danger. The threat is real insofar as the welfare of the individual child is concerned, emanating from the neurotic activities of

the parents as these affect the child's development, particularly his mental development. The mental reactions, in turn, influence the physical reactions. (Actually the effects of the environment are felt simultaneously on the physical as well as the mental level, for these are inextricably interrelated.) The accompanying fantasies are defenses to counteract the fears and other untoward reactions. Fantasies become more elaborate as the child develops physically and mentally and as he has continued experience with neurotic parents.

In Kleinian theory the introjective-projective reaction leading ultimately to individuation characteristic of early stages of life is never lost, and it may be revived with special strength in any situation of stress that causes a feeling of helplessness. Freud felt that the prototype of helplessness was the birth trauma. We have mentioned that Freud believed that nothing we have once possessed (in the mind) is ever lost. Of course, if we thus mean that the "fantasy remnants of archaic assumptions persisting from distorted perceptions of early life" are always present, then we assume two things: (1) the basic life of every infant is a distortion and these distortions persist throughout existence, and (2) in times of anxiety the individual regresses to this primitive level of mental operation. If we believe, however, that the life of the infant is based in reality and that distortion is an aspect of the defenses that accrue as the child meets various traumatic experiences day after day, then we have a different concept of the composition of the mind and of

fantasy as a defense. I support the latter idea.

Since communication provides the basis for group structure, Grinberg's theory would mean that projective identifications are the basis of group structure, an idea that would never be acceptable to the social theorist (psychoanalysts often mistake the projective dimensions of the group members to be the main dynamic in groups). Moreno (1934) pointed out the differences between the various types of communication in groups and their meaning in relation to group structure. The communication system, he said, is based on the choice-rejection motifs on the various members. Choices and rejections are made for many reasons at various times. These are in general the choices made for problem solving and for projective (defensive) reasons.

Bales (1950), Bales and Strodtbeck (1951), and others have amply demonstrated that projections and other "self-oriented needs" interfere with the problem-solving aspects of the group process. Psychoanalysts often forget that in the treatment process we must have an active conscious problem-solving dynamic in operation for analysis to take place. The "observing ego" and reality perceptions must function in analysis—these are essential in psychotherapy and psychoanalysis in order for the individual to resolve his problems. And in the group it is important that the patient understand the problems of each individual member as well as the group process. Patients, however, present for our information in the group both the reality picture of

their lives and their distortions of reality as well. These two levels of behavior interact in the dynamics of a therapy group (Wolberg, A., 1977). The interplay of reality and distortion is evident in the one-to-one situation as well. The analyst (therapist) must understand that the distortions are defenses and contain aspects of the distortions that represent symbolically the reality picture of the patient's situations. Projective defenses are employed in the interlocking defensive systems that emerge as one, two, or more group members identify with each other in respect to their various neurotic behaviors and resist the implications of the interpretations or statements of fact. These combinations in the group have been described by Moreno as "pairing," "triangles," "chains," and the like. It is on this basis that subgroups form. Subgroups related to problem solving emerge, however, as well as subgroups related to defense. At one time a member can be part of a defensive subgroup; another time the same member will belong to a problem-solving subgroup. This can occur in the same session, and the therapist must take note of these changes in order to understand the dynamics of each individual member (Wolberg, A., 1972).

Grinberg (1973) contends that with borderline patients the analyst is unconsciously and passively "led" to play the sort of roles that the patient hands over to him. (In my terms this would be a sadomasochistic role; thus the analyst would be forming an interlocking defensive relationship through identifying with the patient.) Grinberg calls this a partial but very specific

aspect of the countertransference ("projective counteridentification"), but he believes that there is a difference between this kind of reaction on the part of the analyst and "countertransference reactions resulting from the analyst's own emotional attitudes or from his neurotic remnants, reactivated by the patient's conflicts." I find that borderline patients always attempt to involve the therapist in their sadomasochistic pattern, i.e., in their acting-out patterns, even when they know that if they are successful they will destroy the therapeutic process. They hope that the therapist will be able to resist this invitation (seduction). On some level they realize that they may eventually be rejected for their behavior if the therapist tires of coping with the pattern, which involves controlling and enmeshing the therapist as a mode of resistance to treatment, even when the patient wants treatment. I mentioned this pattern in my discussion of the case of the analyst who shifted his theoretical position so as to conduct treatment on the basis of Kohut's theory (case cited in Goldberg, 1978). It was my opinion (1978) that while the analyst was able to establish a working relationship with the patient, he let the patient know that he did not want to act out with him. It was clear, however, that the analyst did not reject the patient for trying to involve the analyst in his neurotic pattern. In this particular case the acting out had a perverse sexual connotation. According to Kohut's view, this acting out would indicate a lacuna in the "self," and the analyst would have to recognize that the exhibitionism was a residual of an unrequited early era of development;

that is, it was an indication of an "unmirrored grandiose self." The analyst would then have to do "mirroring" as the mother should have done so that the deficit could be made up. In my view the patient was acting out a role he had been taught to play by the parents; he was acting out as a projective object of the parents in the interests of the parents' neurotic interlocking defensive system. Transferentially, he was attempting to involve the analyst the way that he and his parents had been involved, and still were involved, even though the patient was now away from the house and working. Identification (I) and projective identification (PI) are defenses that are learned roles (LR) projected from parents.

Grinberg describes two processes, *A* and *B,* that result when the patient leads the analyst on. In process *A* the analyst "selectively introjects the different aspects of the patient's verbal and nonverbal material, together with their corresponding emotional charges," and "works through and assimilates the identifications resulting from identification with the patient's inner world and then reprojects the results of this assimilation by means of interpretation." Here Grinberg assumes that learning about the patient and making an interpretation requires an identification with the patient. This is a use of Freud's developmental theory to explain the dynamics of learning. According to this theory, the individual "introjects an object" (a "form of identification I and then "works through by assimilating the identifications." He then "reprojects" when he interprets what he has learned. (This is a use of

Kleinian theory in respect to the mechanism of projective identification as a function of learning, i.e., a necessary ingredient of the learning process.)

In process *B,* says Grinberg, one of two reactions on the part of the analyst may take place as he is the "passive object of the analysand's projections and introjections." The analyst's response may be due to his own conflicts, in which case he is indulging in a countertransference reaction; or, his responses may be quite independent of his "own emotions" and appear mainly as a reaction to the patient's projection upon him. The analyst may react in one of several ways: he may "properly interpret" and show the patient that "the violence of the mechanism has in no way shocked him"; or he may react in one of four ways if he finds that he is "unable to tolerate" the patient's actions toward him: (1) by a violent rejection of the projection, (2) by ignoring or denying his reaction, (3) by postponing and displacing his reaction to another patient, or (4) by "counteridentifying himself in turn." The response of the analyst will depend on his degree of tolerance.

Grinberg, conceding that Bion has a similar idea, believes that in "counteridentifying" the analyst may experience emotions aroused by the patient through the use of projective identification that to a certain extent are independent of the analyst's own basic problems. Thus, it is not the analyst's unanalyzed residuals that are responsible for his reaction to the patient, but the patient's revolting hostile or untoward behavior that creates the reaction

in the analyst. Grinberg (1973, p. 148) describes one reaction that I would think is definitely a countertransference maneuver: He “will react as if he had acquired and assimilated the parts projected on him in a real and concrete way” and “in certain cases, the analyst may have the feeling of being no longer his own self.” Accordingly, “the analyst will resort to all kinds of rationalization in order to justify his attitude or bewilderment. ”

Grinberg, as has been mentioned previously, assumes that projective identifications begin at birth or shortly after (when neither “ego boundaries” nor “ego relationships” with objects are differentiated) and that they continue throughout life being the means through which communication, empathy, and other such phenomena lead to “understanding” or assimilation. Grinberg's thoughts about the patient’s revolting behavior reminds me of the reactions of W.A. Jones, who called his borderline patients “vampires,” and said that they were ugly and disgusting.

Grinberg believes that in group treatment the emergence of roles takes place from the moment the group is formed. These roles automatically stem from the unconscious fantasies (the basic assumptions) projected by each participant onto the other in the course of their projective identifications. The roles and functions assumed by members of a group constitute the means through which the mechanisms of identification are conveyed. This is also the means through which communication takes place, according to Grinberg. As I

see it, he makes no distinction here between *neurotic roles* and *problem-solving roles* in his conception of group dynamics. Grinberg says that the individual member's behavior or attitude toward playing the projected role (e.g., rebellious leader, submissive member, scapegoat) depends on the remaining members who will largely determine the emergence and the functioning of the role that they unconsciously view as necessary for the group's current situation. Actually, the members of a group come to the situation with roles that have been established by the family, but in the view of Grinberg the roles are derived from a mysterious "id" and are projections of this "id" based on a mysterious "inner core" in each member ("basic assumptions") that emerges at birth from the instincts and is expressed in fantasies representative of the instincts. The "unconscious," or what Bion calls the "basic assumptions," contains the activating motivation for all of the individual's behavior. There is no postulation of autonomous, "normal," "conscious" or goal-directed problem-solving behavior in the early stages of infancy.

Moreno clarified the concept of role (Wolberg, A., 1977) and understood the difference between *problem solving* and *projection.* He thought of transference behavior in the group as the projective aspects of the interactions and recognized problem-solving elements in the group members' interactions as they worked through their difficulties on a conscious level. Thus, he saw interaction as communication but noted the difference between

projective goals and problem-solving goals in the interaction. Although Bion speaks of the "work" that the group does and he distinguishes the work level from the neurotic level in the group, it is not clear whether he conceives of work as problem solving on a conscious level. The exercises Moreno recommended for the group, i.e., role rehearsal and role reversal, were means of bringing insight to the individual through a process of conceptualizing the behavior of the "other" and then acting upon this conceptualization through such means as playing the role and expressing the attitudes and feelings of the "other." By depicting the person with whom the patient was (or is) in an interpersonal bind, the identification becomes clear and insight occurs.

Grinberg (1973) expresses his view this way: Identification is a process basically of "the transformation of a particular ego into another ego." As a result, the first ego behaves in certain respects in the same way as the other ego, imitating and "incorporating" the other ego. The individual identifies with certain reactions, attitudes, behavioral modalities or feelings of the different people with whom he comes in contact, and thus he forms an "empathic link" with the other. (This "empathic link" has been called by many names: bonds, identification, sympathy, libido, to cite just a few.) This link is a "normal" part of identification, according to Grinberg. Once the "empathic link" is established, "it becomes now possible to take the other's place and to understand his feelings. It also evokes a response in the object . . ." The analyst's ability to "understand" the patient and establish empathy depends

upon his ability to "identify" with the patient and put himself in the patient's place. (This interpretation follows Freudian developmental concepts.)

The orthodox analyst says that empathy, which is essential in analytic work, is based on identification (Moore & Fine, 1968, p. 43). Orthodox theory also contains the idea that identification is a "natural accompaniment of maturation and mental development and aids in the learning process" (Moore & Fine, 1968, p. 50). In my opinion identification interferes with the learning process and with understanding, for it is a neurotic process if "one ego behaves in some identical respect like another ego." We should not confuse identification with learning. In psychoanalysis one must work through the implications of identification (i.e., the "not me," the "false self," the "system") that relates to the parents' need for the identifications. This means recognizing certain patterns in oneself, patterns that one may abhor that are like those of the parents. But the analyst is *not* like the patient and has not had experiences similar to those of the patient. Each of us has had our own unique experience. We can only attempt to understand the patient. Identification with the patient would be a neurotic stance.

Grinberg says that projective identifications spring from diverse sources (and are "invariably functioning"), stimulating myriad affective responses in group members and in the analyst such as sympathy, anger, grief, hostility, and boredom. I can understand the analyst feeling sympathy for the patient,

but if one is too sympathetic, one tends to treat the patient in a supportive and perhaps a somewhat derogatory manner. I can understand, too, getting bored at times with a patient, for most psychoanalytic endeavors have their boring moments due to the repetitiveness of some of the patients' productions. In general, however, the therapeutic experience is interesting. To feel anger, grief, and hostility, I believe, is to have countertransference reactions.

Following Freud's libido theory and his "higher" and "lower" developmental scheme, Grinberg alleges that "tendencies and fantasies" of patients "correspond to libidinal phases" and these "give rise to projective identification" with oral, anal, urethral, or genital contents, which add specific connotations to the attendant object relations. In this context Grinberg contends that we "mention those unconscious fantasies projected onto the object in order to eat, chew, bite, or devour at the oral level; to poison or destroy with excrement or flatulence at the anal level; to burn or destroy with urine or its equivalents at the urethral level, etc." In this way Grinberg accounts for aggression.

To support his contention concerning projective identification and communication, Grinberg cites the instance of a monopolizer who was encouraged in this role by the group members in that they made no attempt to restrain him. Grinberg suggests that the group members "laid this

member's role onto him." which he accepted. When this was interpreted to him, he stopped talking in the group. At this point the other members urged him to assume the role that was masochistic, but he remained silent, behaving the opposite of how he had been acting previously. The other members continued to urge him to go on with the masochistic role out of fear of having to "reintroject their own denied roles."

It is rather interesting that Grinberg assumes the monopolizer is engaging in a role that is projected onto him by the other members of the group. It is true that the group members do nothing to control the monopolizer; they let him continue to monopolize and urge him to continue to do so. It is not true, it seems to me, that he derives this role solely from the other group members. They encourage him to continue in this role as an aspect of their own defenses, but such a monopolizer will always initiate the role and *try to control any group* in which he participates. It is one of his defenses against the anxiety of interaction. When the monopolizer stopped talking in the group, after an interpretation, it seems to me that this is a transference reaction, i.e., another kind of defense that was created by Grinberg's interpretation.

The Dynamics of Groups

Jackson commented on the problem of taking into account the

interactions of group members. Rey (1975), whose ideas are described later, states that the problem of understanding the interactions in a group is monumental. Jackson (1957) said that "the incredibly complex picture one obtains in studying family interrelations during family therapy sessions—the simultaneous consideration of more than three interaction instances, is at present, an insuperable task for the mind of man." We must accept our limitations and "make the most of certain aids available." One such aid is "collaborative therapy. The unfolding of the psychic drama as two or more therapists relate and correlate their findings embodies the dynamics of chess and the topological fascination of a jig saw puzzle." Jackson thought that unfortunately, collaborative psychotherapy is difficult because the therapists must deal with each other in addition to their patients." Today the practice of two therapists working in the same group as co-therapists has become standard in certain situations—sex therapy, for example, after the manner of Masters and Johnson, as well as marital therapy, couples therapy, and family therapy. A second aid in conceptualizing, Jackson avowed, was the adding of a "temporal concept" to our more or less "spatial image" of the family. This concept is facilitated by "constructing a picture of the probable family interaction at a period the patient is discussing or at that period where such and such a symptom seems most likely to have been engendered."

Jackson then said that we can utilize "information about the patient's siblings, about the age of one or other of the parents when significant events

occurred, about the differential handling of the children by the parents, and so forth, to help obtain the proper setting for understanding what might have been momentous to the patient at that period of his life." The idea here is to select a kind of slice of life, in time and space, of some period of the patient's past. In my opinion, this "slice of life" should not be thought of purely in the developmental sense, focusing on psychosexual development, nor from the point of view of ego functions that are present or missing, but should be considered from the point of view of the *interferences* that the child has from parents that affect his emotional attitudes toward himself and others due to the parents' anxieties. The emotional development of the child in relation to objects has much to do with the anxieties of the parents and their inhibitory reactions. The actual physical development of the child in the biological sense may be fostered by anxious parents, but their attitudes toward his growing up as an independent being may be inhibiting. Physical development proceeds willy-nilly, and psychological processes such as learning, problem solving, reality testing, judging situations, are always operative as long as the patient is alive.

The effect that parents' attitudes have on the individual's emotional and physical condition and the consideration he has of himself counts most in the evolution of a neurosis (or psychosis). It is in this light that the term "ego development" becomes confusing and ambiguous, especially if we attempt to define "ego" in terms of functions. As defined at present, ego functions are

intact and operative in individuals whether or not they are neurotic or psychotic (see Wolberg, A., 1973, p. 68; also Moore & Fine, 1968, pp. AO-42). It has been established beyond a doubt that, in general, neurotics and psychotics have operative ego functions but that at times these may not be used adequately or normally in specific situations. The "use" may be for adaptive purposes or at times for neurotic aims. Self-actualizing behavior per se is a "given" in human development. It is the reaction of parents to this self-actualizing behavior and the effects on the interpersonal relations between parents and children (the group process) that creates *inhibiting responses* and certain kinds of *defensive maneuvers* on the part of the child. It is true that during periods of development many questions arise in the child's mind and anxieties may develop, but whether these anxieties become the source of neurotic behavior will depend for the most part on the responses of the parents to these anxieties. The problem rests on the parent's own unresolved anxieties, which are superimposed upon the anxieties of the child. Kohut is correct in assuming that mothering—more precisely child-rearing practices —has a great deal to do with the child's concept of himself. The fact is. however, that the child does have a reality concept of his situation with the parents even as he responds to their projections and selectively denies his reality-testing capacities.

Jackson (1937) remarked that considering the difficulties of forming a concept of the emotional interactions of a family group, i.e., in the here and

now, the obvious rejoinder might be, "What is the value of such brain-racking exercise on the part of the psychiatrist?" He felt that two main benefits may ensue: (1) facility in understanding the patient's present situation and (2) theoretical and research implications brought to light by this kind of orientation. One must take into account the "significant others" of the patient's life, said Jackson. This concept essentially agrees with Fairbairn—that in object relations theory it is the behavior of the other (the object) that is important rather than the instinctual drives of each individual. This also seems to be the position of Kohut and Masterson, even though they consider that both instincts and the environment are important.

I believe we shall have to think of "instinct" as meaning in psychoanalysis the genetic factors that promote self-actualizing and self-preservation behavior. We have already mentioned Green's comment (1977) that Freud assumed the basic function of the psychic field was the lowering of un-pleasurable tension. (Freud meant tension from the instincts as the derivatives are expressed in the environment, i.e., with people.) Freud looked upon the lowering of tension as an important factor both in development and in adaptation. Today we know that tension reduction *is* important, even life saving. We find that tension is created by the environment and often is increased by the individual's reactions to the tensions of important family members. When the individual is frustrated, this often leads to destructive tension-relieving behavior, i.e., to displacement behavior.

In my opinion the research value of family therapy is very important. The therapeutic benefit derives from helping the parents change their behavior with the child as their tensions and anxieties are reduced through understanding. Family therapy gives us a great deal of information about how the family group functions, and it provides a most important living example of the dynamics of family life in a given family society at a particular period in time. In relation to neuroses and psychoses, the interlocking defensive system is evident in the family being observed, and the therapist becomes aware of the cumulative effect of family relations on the various children who must relate to neurotic parents. The need of the parents to have children act out is obvious. The different kinds of relationships the parents make with different children are also revealed. Whether we are doing group or individual treatment with borderline patients, all astute therapists, through relevant inquiry, should uncover the family picture to gain the kind of information that Jackson suggested of certain periods in the life of the patient, i.e., *those periods that seem crucial to the patient.* The therapist must learn, however, to distinguish between those periods that are important but are, nevertheless, in the telling being used in the session for defensive purposes rather than to work through a conflict.

Originally, Jackson studied psychosomatic and physical problems in patients. As he began to see the influence of emotions on these conditions, he sought psychoanalytic training. Later he was to work with schizophrenics in

both individual and group sessions. He coined the term “conjoint therapy,” recognizing the value of both individual and group treatment. He realized the importance of family dynamics in the perpetuation of a patient’s neurotic and psychotic problems, and in 1957 he wrote the important paper: “The Question of Family Homeostasis.” This paper suggested that, in the neuroses, and particularly in the psychoses, the effect of the parents' behavior was to keep the family system as “closed” a system as possible. (The family can never entirely be a “closed system,” but the attempt is made by the controlling and anxious parents. A truly closed system tends to disintegrate.)

In sociological literature doubt is cast on the concept of homeostasis as a factor in the persistence of groups. The opposed concept states that *change is a constant variable in human life and that a theory of equilibrium should be substituted for the concept of homeostasis.* This concept recognizes that change creates temporary disequilibrium, and disequilibrium is probably just as constant and necessary as homeostasis for the phenomenon of change. The idea is that in a social group or social system, disparate opinions create the possibility of change and this is cause for disequilibrium. But as the members of the group accommodate and assimilate the implications of these various inevitable changes through discussion, a consensus occurs that provides the basis for a decision. A *norm* must be arrived at, which creates a standard (of opinions) related to what the members should do about a given matter, i.e., how they should behave in a given circumstance. The group therapist’s role is

to help the members create the atmosphere where adequate changes can take place. This means unlocking the cohesion in the defensive systems among the members and helping to create the kind of problem solving that will enhance the positive goals of each member. Jackson made lasting contributions to the field of family therapy and his colleague Weakland and others are carrying on and extending this work.

Among recent papers on group therapy that deal with the treatment of the borderline is one by Rey (1975). Superimposing the developmental concepts of Melanie Klein as well as utilizing some of Chomsky's ideas, Rey proposed that, due to lacunae in the ego, patterns of acting out, which are evident in the group, have been laid down in the "primitive stages" of the "paranoid-schizoid position," that is, in the first three or four months of life when the patient's "internalized objects" belong to the earliest or sensorimotor (prerepresentational) stage of development (Piaget). This includes the "part-object stage" (Freud's autoerotic stage). Rey postulates that in the case of borderline patients the "constructs" or "schemas" of the mind have remained "unlinked" with words, due to "splitting." Rey surmises that in the early "part-object stage" or even in the early "whole-object stage" of narcissism, the defense of "splitting" is usually used because of the infant's excessive amount of innate oral aggression, as Klein and Kernberg have emphasized. The infant who will become borderline *never* goes beyond this period.

Rey suggests that the use of "action therapy" in the group, i.e., "nonverbal types of communication" [psychodrama] will supply the linkages with word representations that have never taken place. Rey states that the "preverbal stages of internalized action schemas" have to be undone in treatment, and he suggests that encounter techniques be used, inferring that perhaps these may contain the "nonverbal meanings" that verbal communications would convey. The nonverbal communications may serve as a medium to buttress the verbal communications of the members of the group. To depend on purely verbal schemas, he says, would mean that we would be attempting to alter the "original action schemas" (those laid down in early infancy) at the level of "phonetic symbolizations"—or, in Freud's terms, at the level of "surface structures"—rather than at the sensorimotor level of the part-object stage. To make the appropriate connections with nonverbal aids would be to help the individual in making up the lacunae. Thus, we would assist the patient in the manner in which the infant proceeds from the sensorimotor stage to the next stage of development, i.e., from the part-object stage to the whole-object stage of narcissism.

Rey thinks that in group therapy with borderline patients, the group members can act as "transitional objects" (Winnicott's terminology); that is, they can provide the "linkages" for the patient who is acting out and who has not made these "word representation" connections in his own development. As the patient accepts the linkages from the group members, he gradually

"internalizes" them. This, Rev believes, is a form of identification with the members of the group. For Rey acting out means that no true identifications have been formed and that there are "no linkages between action and verbal connotation." (A common practice of psychoanalysts in my opinion is to project into the group process developmental phenomena, thus displaying a misunderstanding of multidisciplinary thinking.)

While we may not agree with Rey's theory, we do understand that psychodrama can be an important vehicle to use when the patient denies, represses, or dissociates. Psychodrama is a way of emphasizing reality factors and is employed to help the patient gain insight with the hope that he will use the insight to change some of his neurotic behavior. The problem with Rey's idea is that the "linkages" do exist in the patient's mind, but he denies that they are there due to his great conflict. I believe that Green too has described a denial mechanism rather than "lack of linkages" in his concept of "splitting." How do we know that linkages exist? That there are no lacunae? One of the most useful methods of refuting the theory of lacunae and the lack of linkages is through the use of hypnosis. Lewis R. Wolberg presented a paper on hypnosis at a Macy Conference in 1952. One of the comments of Rapaport during that presentation was that psychodrama as well as hypnosis can sometimes break up repression to a point where the patient will respond to the analyst and express what he has been repressing. (Not only are memories repressed but current transference feelings can also be repressed and usually

are denied.)

Another way to understand that the linkages exist is to utilize the projective therapeutic techniques that I have suggested in working with the borderline patient to deal with what is denied and repressed. The verbalizations that take place between analyst and patient as he describes the behavior of the "other" with whom he is identified, and whom he uses as a projective object, tell the story of what is being avoided or disavowed. What the patient says about the "other" applies to himself as well. My session with Maurice Belk (see Chapter 11) illustrates this technique. The verbalizations about the "other" that accompany the patient's projections show that the linkages have been made although they are projected. Repression is found to be an important factor in the denial, and this can readily be demonstrated by hypnosis.

The results of adequate psychodramatic technique *show the connections with repressed material* rather than *"providing linkages"* that never existed. In encounter groups psychodrama is one of the main techniques in the "games" that people play. The goals are cathartic, and an effort is made to have the individuals "talk out" as well as "act out." Often a great deal of emotion is elicited before talking is evoked. The aim of the individual who participates in an encounter group, I believe, is to break up his detachment and depression so that he can *feel.* There can be in the borderline patient a "split" between

psyche and soma—or between mind and feeling. It is not a permanent split but a dissociative process used in periods of intense anxiety. Another way of looking at this “split" is to see it as a hysterical mechanism to control feelings and to maintain distance, using denial as a main defense. There seems to be in the infant a “given" that probably has a great deal to do with the ability to detach, to dissociate, and to concentrate or to withdraw. We mentioned that the infant can “tune in" and then “tune out” when stimuli become too irritating, or he can fall asleep to avoid certain stimuli. This, together with the neurophysiological mechanism discovered by McCarley and Hobson (1977) will account for the ability to develop hysterical defenses such as the dissociative phenomena and denial. But just as the ability to imitate may have some bearing on the capacity for identification, so “tuning in” and “tuning out” may have a relation to hysterical phenomena, but these phenomena are not the same. Imitation is not identification or learning, and the infant's ability to “tune in” and “tune out” is not the same as hysterical phenomena such as *denial*, dissociative processes, hypochondriacal attitudes, and the like.

Rey, (1975) as we have mentioned, considers the group a “transitional object” rather than a peer system. He does not in his 1975 paper say that the therapist is a mother, but he does tend to think of the group as a family. The fact is that neurotics and psychotics tend to project the family hierarchical structure into the peer group. It is this projective (defensive) phenomenon that encourages some therapists to think of the therapy group as a family.

Since both Rey and Grinberg have a Kleinian orientation, they look upon group life as determined by Klein's interpretation of the dynamics of projective identification. Rey, for example, says "an understanding of group dynamics" will depend on understanding how "intrapsychic groups" work. It would seem to me that an understanding of those dynamics that evoked the neurotic defenses in individual members. It will enable us to see that the patient's repetitive fantasies (his "intrapsychic groups" or his "not me," or his "false self," and so on) all have a relation to the traumas associated with accepting the identifications over time at the hands of his parents. The repetitiveness of the parents' neurotic behavior is a factor in the perpetuation of the "inner objects," or what I would call the *identification fantasies.* An understanding of group dynamics will give us insight into how the so-called "intrapsychic object relations" have evolved. But these "inner objects" represent not only "primitive" or early objects, they also represent the relations with parents throughout the time that the individual is interacting with the parents, which can extend into adulthood. I would consider that "intrapsychic groups" mean the internalization of external and traumatic relations with important persons in the patient's environment that are disguised in the form of fantasy. I believe that "inner objects" should connote only the mental representations of the object relations relative to the identifications with parents, which may be disguised. The repetitiveness (repetition compulsion) should be interpreted to mean "incompleted tasks"

due to conflict, inhibitions, and defenses (the Zeigarnik effect.[14]). Unless we define "inner objects" in a restricted way, the term would imply all relations that the individual has throughout his life time with objects (both animate and inanimate). In that case the definition would be so broad that it would have no scientific value.

A final way to refute the idea of "lack of linkages" is to recognize that all acting out is related to fantasies that constitute the direct linkage between interaction with parental figures and identifications. The fantasy is a representation of the meaning of the identification. It is a repetitive phenomenon and is a factor in the defense acting out the identification. Freud alluded to the fact that fantasies were associated with acting out; the essay on hysterical fantasies and their connection with bisexuality indicated this relationship. In his earlier papers symptoms were considered to be hysterical in nature and bracketed to identifications with important people in the patient's life, but the activity in relation to symptoms was not thought of at the time as an acting out of a fantasy. The fantasy was considered by Freud to be a fantasy instinct (later the id) rather than a consequence of experience with important persons.

Rey (1975) wrote that the important thing is to be able to evaluate how "the existence of groups of inner objects and primitive intrapsychic object relations [what I have called the sadomasochistic identification fantasies]

contribute to an understanding of group dynamics" as these operate when the patient is in a group therapy situation. As mentioned, these identification fantasies (the inner objects) are not the stuff from which the total group dynamics are made. When the fantasies, however, are acted out in the group, or anywhere else, they constitute a special dynamic related to the transference. The self-actualizing behavior is an aspect of the group dynamics having to do with thinking and learning associated with the autonomous functions used in problem solving. If we define "inner objects" as identification fantasies, then we shall have to say that these fantasies are the essence of the patient's unconscious, at least that part of the unconscious that relates to repressed or denied and disguised memories. We can understand the connection of the fantasies to the historical relations with parental figures, disguised in their various forms. The interactions in the fantasies represent the meaning and significance of the interactive behavior that evoked the identifications. All acting out. therefore, is defensive and represents some form of transference behavior. It is based on identifications with persons who are influential in the life of the patient. The links to the identifications can be found in the associations and in the analysis of the fantasies and dreams.

In a group we can understand the way in which roles operate whether these be neurotic roles (Wolberg, A., 1960) or adaptive roles since we see these roles performed before our eyes. As therapists, we can also *relate the*

neurotic roles to the patient's fantasies if we understand that the patient's projections are stimulated by his fantasies. His verbalizations concerning his projections have meaning in relation to the situation he had with his parents when he learned the neurotic roles. As therapists, we must be able to distinguish between aberrant and rational roles as these operate in the therapy group. The patient brings a repertory of roles with him into the group, and as the members of the group interact (i.e., communicate), these roles are set into motion. Every person has certain "normal" role behaviors that he enacts at certain times, even neurotic and psychotic individuals; and these "normal" roles operate in the therapy group too as a function of the individual's reality system. The patient functions simultaneously in two ways: adaptive and neurotic—and in relation to these interacting ways he operates both consciously and unconsciously.

We know that the patient's emotional problem, as it is revealed in the group, interferes with the therapeutic group task of helping to eliminate the neurotic and/or psychotic problems of each individual in the group. As Moreno (1934) and Jennings (1950) pointed out and as I have reiterated (1972, 1976), there are at least three dimensions of the behavior of individuals in the group related to group dynamics that the therapist must consider: the *projective dimension*, the *problem-solving* dimension, and the choic*e-rejection dimension.* When one thinks of interactions (communications) in the group in terms of these three categories, it helps to

organize the data in borderline conditions that one perceives so that meaning emerges and interpretations can have greater effect.

It is important to remember that at any given time in psychotherapy we deal with only *small* aspect of the patient's "total mind," namely, that part of the mind that is concerned with the emotional problem, how it affects the patient's adjustment, and what can be done about this problem. The focus is on the "here-and-now" events that occur in the group. When we say the here-and-now events, we do not mean that the group does not talk about the past, but when the members do discuss the past, it is because the here-and-now interactions are reminders of past experiences. Or, to put it another way, the conditioned responses of a given patient may seem inconsistent with the present situation and the question arises, "Where did this response come from?" The current situation seemingly is not one that would normally evoke such a response. This means that the patient sees the other in a different light from how the remaining group members are seeing him and the discrepancy is so great as to require explanation. In this case the patient sees the "other" through his fantasy. As communications become less vague, group structure changes, and the group proceeds with its task. Resistances (defenses! do occur, and pauses in group work toward the task take place for a regrouping, which occurs as one phase of the task is accomplished and the group prepares to go to the next sector of its general goal. At one moment *A* will communicate with *B* for purposes of defense; at another point that same member *A* will

communicate with *B* to work out a problem. Or *A* will communicate with *B* for defense and will communicate with a third member *C* for working out a problem. Communication at any given point will depend upon the member's need at the time. The task of therapy is not easily gained with borderline patients due to the interference that their neurotic patterns (i.e., their defenses! provide to counteract the problem-solving process.

As Rey pointed out, there are "subtasks" to be accomplished in the therapeutic group. One of these subtasks is to have the members understand the relation of each member's fantasies to his life pattern as these evolved in their families and are now reflected in the group. Actually, what we want in the therapy group for the borderline patient, and for others as well, is for *each member to understand the relation of his fantasies to his acting-out pattern as this operates with members of the group and then to relate this to the defenses that were operative when the parents began to insist upon the acting out of the identification roles.* We must arrive eventually at the hard fact that in identification our patients are in some manner *like the hated and denied aspects of the parents*; and we must uncover and reveal through the patient's associations what this means to the patient in his responses to the group. The feelings that are associated with neurotic (identification) roles have to do with self-contempt, with fears of acting out revenge patterns, with inhibitions in expressions of love, and expression of autonomous behaviors at certain points in life, in relations with others.

Rey suggested that "dissociated patients," whom he calls borderline, are, in the group, an assembly of subgroups of unrelated parts. They are "concrete projections of autonomous primitive groups" (inner objects). (The patient may have dissociative tendencies but is never so dissociated that he is a "concrete projection of a primitive group" unrelated to the current group.) The therapist is also "confronted with people about whom the patients talk, says Rey, i.e., "real external people, however fantasy distorted they are," and the "complication of human interpersonal relationships" for all these parts become "flabbergasting." (If we keep in mind the three dimensions of behavior in a group [see p. 154] for organizing our data, we shall not be so flabbergasted.)

Grinberg and Rey assume that the projective identifications of the patients are what determine the group dynamics—in the family, in life, and in the therapy group—but as Moreno (1934) pointed out, the dynamics of groups have dimensions other than the projections of the patients, dynamics that are far more important in the maintenance of group structures. Group life can go on without the projective identifications of the members of groups. The problem-solving capacities and the group norms are the essence of group structure and function, and no group can exist without these binding elements, neither a therapy group nor any other group. It is the problem-solving motif that Rosner (1969), for example, in his essay on "working through" refers to when he says that creativity is more important than the

neurotic traits of the patient. When we emphasize the conscious activity of the patient as being of most importance we are not discarding the idea of the "unconscious." Repressions create the unconscious elements in human behavior that have to do with emotional problems, and while the unconscious is a strong motivating factor in neurotic behavior, in my opinion, during therapy reality factors, creativity, and problem-solving capacities are more important to consider from the point of view of working through the emotional conflicts.

Splitting, Denial and Lacunae

Dince (1977), like Green, has touched upon the subject of what I call *detachment and denial by hysterical means.* Dince speaks of "dissociation," which he considers to be a primary trait of borderlines related to a conscious desire to deny certain aspects of reality. In this sense the denial, I feel, might be said to be bracketed to a kind of self-hypnosis; *denying that which one does not want to know, but does in fact know.* I think that denial is always associated with acting out the identification role and that the acting-out process may be in the nature of a post-hypnoticlike suggestion as Jackson (1954) mentioned in an early paper. Stern (1938), as we have noted, referred to the "suggestibility trait" in the borderline patient, and Freud spoke of the "suggestibility" in all patients attendant upon the masochistic traits (Wolberg, A., 1973, p. 27). The masochism would be due, it seems to me, to the fact that

the parents have forced the identification role on the child through their repetitive and obsessive demands and suggestions, conveyed both verbally and nonverbally. Finally, the child acts out the role even though originally he fought against it; but he denies the origins of his behavior.

Dince writes of a phenomenon similar to the one described by Green, but suggests this may be the result of certain self-hypnotic phenomena (hysterical?) that may be seen in cases such as the woman who has sex and denies any feelings although she lubricates freely. (This is what Green calls a "split" between psyche and soma.) In this kind of situation there are two "selves" that are dissociated, says Dince, or exist as partially dissociated states (Kernberg's "ego states"?), and he refers to Cornelia Wilbur's *Sybil,* and Laing's *Divided Self.* I find that the kind of symptom Dince is describing is often present in the borderline patient. The defense should perhaps be thought of as denial rather than a dissociation. I suggest that we might confine the term *dissociation* to a description of the denial and disavowal mechanism in multiple personalities, in persons with fetishistic symptoms, in homosexual characters, and in schizophrenics who display certain bizarre acting-out mechanisms, since the dissociative defenses of the borderline patient are much less severe. The borderline patient does have depersonalization episodes, but these are fleeting and momentary; at worst they occur minutes at a time so that they are not too extensive. Dince reported that one of his patients read the books of Wilbur and Laing and was

affected by them: “What began as a consciously directed process on a fantasy level became more and more systematized and less controllable” (1977, p. 335). Dince believes this is not the same as detachment or denial as defined in psychoanalysis. (Could it be that particular patient might well be schizophrenic and the symptom might be of a continuous obsessive nature?) These mechanisms are based on denial of highly charged aggressive or sexual affects, contends Dince, and the consequent dissociative action account for much of the symptomology of the borderline, as well as for some of the typical patterns of behavior that the borderline acts out during the analytic session. I have found that in the borderline such symptoms are sexualized and associated with perverse feelings and fantasies of a disguised aggressive nature, related to the identifications.

It has been my experience that individuals who have “dissociated selves,” such as those referred to by Dince and others, or persons with strange behavior who wish to be a different sex and go about trying to “convert” their gender, or people who act out with members of the opposite sex in grotesque ways, or people who have weird amnesias or bizarre multiple personalities are probably not borderline—rather they are schizophrenics. Some phobic personalities are actually schizophrenics, and in the course of analysis they show widespread dissociative tendencies. There is, for instance, one of my patients, Sonia, who is an extremely successful woman but who refuses to “feel anything” in relation to her success. Her success she

says is of “no import,” it gives “no pleasure,” and the like. Her “agonies” are much more important to her than her success. This is similar to Dince’s woman who has sex and lubricates but has no feeling and Green’s concept of the dissociation of psyche and soma.

One of my patients, Elizabeth Osgood (Wolberg, A., 1973, pp. 242-251) had this kind of symptom in her sexual relations. There is no reason to think of these defenses, insofar as I can see, as other than hysterical. However, they are different from the hysterical defenses found in true conversion reactions, the amnesias, and so on, since the dissociations in these are more pervasive and thus have a different effect upon the patient’s life style. Elizabeth usually, when discussing sex, spoke of her father (with whom she was highly identified) as having “no feelings,” being “all intellect.” She described him as a firmly detached person, however, highly esteemed, as a professor in a prestigious university working on research of a “classified” nature. His prestige was apparently emphasized in the home, so that it would seem like a kind of sacrilege if a mere child should differ with the socially established and sacrosanct opinion of a person of this nature. Idealization of the father was a family business. Idealization helped to keep Elizabeth’s criticism and anger toward her father concealed and held in check. He liked to putter around his workshop, and Elizabeth always felt that the only time he paid attention to her was when she made it her business to go to his workshop and ask questions about what he was doing. This made her feel that her father wished

she was a boy. He had two sons. Elizabeth's brothers, but they both had emotional problems. One brother startled her one day by telling her that he was homosexual.

It is confusing to try to follow Freud's developmental theory here attempting to put these symptoms on a "lower level" of development than the hysterias, accrediting them to a hypothesized hypochondriacal (semi delusional) stage of infant development, considering them remnants of a pre-oedipal period. In Elizabeth's case, upon probing, one discovered a fantasy of a taunting father, a masochistic feeling, and a sadistic pleasure in denying gratification to the man with whom she was having sex. The sadistic side of Elizabeth's fantasy eluded me for two years, but it became clear when she began to have dreams of men who could not "handle her" and who could not give her sexual pleasure. She acted out this fantasy by finding men who took on the challenge of giving her an orgasm, only to fail. (Is this an oedipal problem or is it s hypochondriacal mechanism of preoedipal type?)

Rosner's 1969 and 1973 papers have been referred to in our discussion. They tend to refute the "lacunae" or "defect" theory of ego functions and explain the dynamics of "free association," which Rosner assumes are operative in all patients. It seems to me that therapists who are not clear as to a patient's dynamics and so do not distinctly recognize what they see and hear in the session make up a theory to account for what they believe is going

on. The theories of “lacunae" and “defect” and “lack of linkage” fall into this category. Besides being false, these theories require that something be done that has already been accomplished by the patient many years ago. The patient realizes the therapist’s theories that are presented to him are wrong, but he hysterically blinds himself in faith (a masochistic maneuver). He hopes that the technique being used will do the trick in relieving his anxieties, yet doubting all the time that this will be the case, and he utilizes the situation to buttress his defenses. The therapist. it is avowed, can utilize his countertransference feelings therapeutically. The argument goes that if the therapist is truly cognizant of “how he feels” towards the patient, even if he is angry and hates the patient, this is all to the good because he can point out that not only the therapist but other people feel the same way toward the patient. The patient’s actions are such that they inspire these feelings in all people. In other words, the patient's behavior tends to make him rejected and hated, and he deserves to be rejected and hated at times by the therapist as well because of untoward behavior. It is my opinion that the therapist who truly understands the dynamics of the borderline patient will never have to depend upon his countertransference feelings to bring him through a session, for very few such feelings will arise. The more clearly the dynamics are conceptualized, the better chance the therapist has of relating to the patient at any given moment and the less anxious both the therapist and the patient will be in the session.

The unresolved masochism of the patient is often the cause of the hysterical phenomena we see in the borderline patient. This was evident in Flora, who had to look for another therapist since I was not in town often enough to see her regularly. She decided to be treated cooperatively by two different therapists who worked independently, one a behavior therapist and the other a psychoanalytically oriented therapist—both concentrating on the phobia in different ways. After one year this procedure was of no help; yet she kept going to both therapists. When she had been in therapy with me, we had not worked out her transferences, positive or negative, toward me, and she insisted on seeing me when I was in town. I had mentioned another therapist for her to substitute for me, but she would not take my suggestion. Her masochism apparently kept her in a bind.

Over the years I have worked in depth with more than thirty borderline patients and have supervised patients of other therapists as well. The masochism of these patients is extensive and self-defeating. Many of my current ideas on the borderline personality are based on a survey of thirty-three borderline patients in my own practice. These patients are listed on page 263 with, of course, fictitious names to conceal their identity. In the course of treating this group I met and interviewed fourteen sets of parents and had indirect contact through letters with two more sets. There is no doubt in my mind concerning the denigrating sadistic attitudes of these parents toward their children, particularly toward those who became

patients. Of the thirty-three patients, only Sonia Gerber, Flora O'Toole Levy, and Gertrude Belan came from poverty homes. As adults, all were very well off financially except Gertrude Belan and Sonia Gerber; the latter, however, is now comparatively affluent. For years while in therapy she struggles unnecessarily hard to support her parents, masochistically denying that the burdens she assumed created rage and revenge feelings. She used the situation as a defense while denying and excusing the sadism of her parents and of herself. Harriet Hamburger, too, had years of masochistic work activity and self-defeating social relations before she finally broke loose from her self-punitive bonds. When she did, her economic status rose rapidly. After she became financially solvent, she spent a few more years in successive masochistic relationships with psychotic men before she finally extricated herself and found a "normal" partner.

I cite this information to suggest that 91 percent of the thirty-three borderline patients came from financially secure homes, yet all were abused or denigrated emotionally by their parents and both directly and indirectly sexually used as projective objects. The sadomasochistic partner that the borderline patient needs neurotically is reflected in transference, often eventuating in a negative therapeutic reaction. The masochistic appeasing and idealizing attitude is expressed in what Freud called the "positive transference." When Flora was finally able to express regret over my leaving town so often and said, "Well, that is life, that is how it is," she then found a

therapist whom she recognized as adequate and who could help her. She feels content with this man, and she no longer seeks me out. although she does occasionally speak to me on the telephone. The denial in Flora's case related to the fact that it was obvious she could not resolve her problems with these particular therapists yet she persisted, idealizing them and refusing to go to the therapist I had suggested. This refusal and denial was associated with the negative transference which, in the beginning, she refused to consider.

I have learned over the years that these patients often conceal their most destructive masochistic behavior, which sometimes assumes a suicidal intensity. Flora hid from me the fact that she had a lump in her breast. It is advisable for therapists who have borderline patients to ask pointed questions in order to ascertain the physical and mental possibilities and potentialities of masochistic attitudes. Often the masochism is not as obvious as the sadism, and one tends to discount the masochism in such instances. Both homicidal and suicidal tendencies may coexist. The homicidal tendencies reside in the sadistic trend and the suicidal in the masochistic behavior. Flora had a "good" son and a "bad" son; both were exceedingly neurotic. The "bad" son she fought with continuously, driving him away from the family while professing a desire to be close. She helped both sons financially. She finally had a fight where the "bad" son hit her, and thereafter she said she was very much afraid that he would kill her. Even though she had been most provocative and certainly played a role in instigating the physical

assault, she professed innocence. The “bad” son settled down with a homosexual partner who helped him find lucrative work and encouraged him to get off drugs. He has made a good work adjustment and has left the drug scene. His homosexual partner has had relations with women but has found it difficult to maintain such relationships. The “bad” son has been rejected by women because he cannot maintain an erection when having sex. He had used his homosexuality previously as a way of soliciting money to buy drugs, but he is no longer a “prostitute” nor is he using drugs. The “good” son is a failure. He masochistically seeks jobs that are below his capacities, and when in a position that is equal to his talents, he loses the job either by fighting with his boss or by not going to work. He was a dropout from college, where he mainly served as a pusher; he maintained himself and his drug habit by selling drugs. At present he is still on drugs. This young man cannot bring himself to get into any kind of a therapeutic regimen that might conceivably help him.

The Observing Ego

Rosner (1969) has written an interesting paper containing many points that are not usually considered in working with the borderline patient. He says that psychoanalysts speak of the “contract between themselves and the patient.” and in an examination of the concept “contract,” Rosner writes, we find that what is meant is that the patient must be able, in spite of his

resistances, to cooperate with the analyst in the therapeutic endeavor. This means that he must be able to conceptualize and recognize, at least in part, *some aspect of his problem* so that in this area the analyst and analysand are reality oriented in their joint work. It is expected that the analysand will be able to follow certain kinds of dynamically oriented instruction that make this particular relationship psychoanalytic rather than some other kind of an interpersonal relationship. In other words, there is a definite problem-solving capacity in relation to the goals of psychoanalysis and the roles of analyst and analysand. It is assumed that the patient can engage in certain kinds of problem-solving behavior, that he can reach defined goals, and that these goals are different from problem solving in some other types of process, such as learning how to play the piano, learning arithmetic, or solving a problem in chemistry. Through this particular psychoanalytic behavior the patient is presumed to gain insight.

Rosner says that *associations are important in the psychoanalytic process* even with the borderline patient, and can be influenced by: (a) the reality situation: with the analyst, with friends, and with others; (b) the day residues: how the patient has handled today's reality; (c) the emergence of warded-off drives from past experience, i.e., through memory and the “affects associated with the memories,” e.g., feeling “good” and “bad" about certain events in the past; (d) by the interpretations of the analyst; (e) by the impact of leaving a task (analysis) and returning to it session by session (the Zeigarnik effect?);

(f) by insights through selfinspection and the thoughts of the analysis when away from the analyst.

Insight is a complicated process “best described by learning theory," according to Rosner. It is a part of problem solving, and Rosner attempts to reconcile Gestalt theory and psychoanalytic theory to explain how associations can become stimulated by insight and vice versa. I believe that we might define the *psychoanalytic process* by saying that it is a way of learning about one’s neurosis or one’s psychosis and how this relates to experiences with parents and then doing what is necessary to eliminate or reduce neurotic or psychotic behavior by changing the defensive system or eliminating certain defenses and substituting for them assertive behavior without fear or guilt. Defenses are maneuvers, such as repressions, denials, and other mechanisms associated with both conscious and unconscious ideas and feelings. (In this kind of postulation we would say that the original anxiety began in the family in relationships with parental figures rather than during the birth process.)

Associations are, of course, one of the roads, if not *the* road, to the unconscious, that is, to the *repressed material* that one must uncover if one is to help the patient. Associations are the means through which repressions can be undone. They lead to an understanding of neurotic patterns. But, says Rosner, once there is this understanding, there must be a way of “working

through" so that there is *changed behavior.* (Borderline patients—due to denial, the obsessive mechanisms, and the hysterical symptoms—have difficulty learning about the anxieties and the conflicts and accepting the idea of defensive behavior since the syndrome is organized in the overall context of a projective identification defense, a prominent part of which is an acting out of the transference rather than a talking about the transference. Like all patients who undergo any kind of psychoanalytically oriented psychotherapy, borderline patients do produce associations. Normally, these are concealed, in the beginning phase of treatment, by speaking of others and in the context of what is denied.)

Under *insight* Rosner lists several types of phenomena that he argues have a relation to learning, and he quotes from experimental work to support his hypothesis. He suggests the use of the concepts of *structuring, conceptualizing, psychophysical isomorphism,* and *problem solving* as contributions from the Gestalt field. He refers to Duncker's (1945) variety of dimensions in problem solving; Wertheimer's (1944) "similar operations" in productive thinking, and Kohler's (1929) classical experiments demonstrating insight operations. The very subject matter of analysis assumes causal relationships and an organization within the context of a total structure. Rosner brings to mind the Hoffding function (1910 [1968, 1977]), similarity of context for recall to occur and the fact that there is an interrelatedness in associations. Associations are not haphazard; they are a

"pattern" a dynamic "whole," containing "contrasting" or "opposite" ideas. (Anyone who has lived to have experiences has a past, and this past is subject to certain laws of association in relation to the "present.") In interpretation the patient is faced with a high degree of ambiguity, "allowing greater play of central factors and thereby exposing distortion to a greater extent. This would also constitute a rationale for the couch." But, Rosner goes on to say, there is evidence to support the idea that the *creative impulse* is far more important in treatment than the neurotic impulses, and this evidence comes from a variety of sources. This important principle is one that is clearly forgotten by most therapists when they are engaging in the treatment process with borderlines, for it is assumed that these patients have no reasoning capacities and are totally dependent and focused on fantasy. Kohut seems to be an exception to this rule, and several psychoanalysts from the Homey School have emphasized working with the constructive side of the ego, i.e., the creative side. In my first paper on the borderline patient, I also stressed this principle, which derives from learning theory and which, at the time, I called "positive ego construction" (1952, pp. 705-707). At that time I also believed that the ego had "holes" (lacunae) and that in the treatment of these ego deficits they had to be "filled in." Today, I relate this problem of lack of "positive ego" to the sadomasochistic pattern and the various types of defense against anxiety rather than to "defects" or lacunae. It is my belief that the ego of the borderline has a special type of sadomasochistic organization which

accrues in the family situation.

It is admitted by all psychoanalysts that the “observing ego” is essential in analysis, says Rosner. and he disagrees with those therapists who say that borderlines and schizophrenics have no “observing ego.” In this I quite agree. (The “observing ego” is intimately connected with the creative impulses, and these are present and operative in the borderline patient, as we have just noted. In the first few days of life (i.e.. after the fetus has changed its status through the process of birth to a relatively independent being) behaviors that are autonomous are displayed in addition to the so-called reflex behavior, which, incidentally, is much more meaningful for development than was originally supposed. These autonomous behaviors include the ability to “tune in" and “tune out" (Caplan. 1973, p. 28) capacities that aid in the various types of learning that occur as well as serve to defend against too much or unpleasant stimulation. “Tuning in" and “tuning out” also is a mechanism that relates to the “isolating process” involved in concentration and attention and makes possible the dynamics of the observing ego.)

Rosner's paper reminds me of the fact that Freud felt that associations and the “constructions" that one could assume from the associations were the road to the unconscious. Freud once pointed out that some dreams *tell the whole story of a neurosis (or psychosis)* but that in dealing with them we must proceed piece by piece, due to the problem of “resistance.” I believe Freud's

resistance means defense (this includes transference), and so we must gradually put pieces of the total together as the resistances are overcome. It is my impression that resistances (defenses) are overcome by outlining them, judging at what points they go into operation, *and understanding what the fantasies are that precede the patterns of behavior that constitute the resistances. To understand these fantasies, it is necessary to review situations in the here and now that set off the fantasies and neurotic patterns, then analyze these fantasies and neurotic patterns. The fantasies must be analyzed in relation to the present,* thereafter making connections with the past between the fantasies and the neurotic patterns. How to do this with borderline patients who act out their fantasies rather than consciously experience them is a problem, and this determines the type of psychoanalytic technique employed in the early phases of treatment. It is the coping with the acting out and relating this to the *identification fantasies* through the associations that require that the treatment of the borderline patient extend over several years. In the beginning and sometimes for a long period, for example, the fantasies related to idealization cannot be dissipated. (In the *short-term treatment* of the borderline patient, we focus on one small part of the problem, disregarding the major defenses, helping the patient to work through the focused aspect of the difficulty. We hope that the experience will enable the patient to generalize and recognize a similar situation in the future, working that through by himself.)

The borderline is said to be typically dissociative, and this interferes with the utilization of insight and the expression of association. It is true that the patient often has a negativistic attitude that he holds onto—a kind of attitude of “I will not let this son of a bitch influence me.” This makes the utilization of insight difficult. It is an acting out of the transference, a resistance to the controlling parent, projected into the analytic situation.

My patient, Sonia, had this problem; she could not accept consciously the idea of any kind of “control” from another person, although she utilized her parents' control for years and would not budge from that position. Her masochism was intense and seemed almost impenetrable. This struggle was very important to her sense of integrity and safety. She idealized her willingness to be trapped by her parents and to have to “take care of them." She was the "good” child, her sister the “bad" one. Kernberg might interpret this “good" and “bad" (as Sonia allocates the roles to her sister and herself) as not being willing to see the good and bad of the parents and of herself. In a sense, this is true. The projection of the “good" and “bad” of the parents is seen in the good and bad sisters. This was not a true dissociation, however, since Sonia did, on occasion, talk of the hostility of her parents. However, if one picked this up. she would deny it vociferously. It is this kind of mechanism that is called *dissociation* in the borderline. There is a consciousness of the facts while there is denial so that it is not a true “splitting.”

Sonia also had a “bad object" (splitting and the projection of aggression) in her cousin as contrasted to herself, the cousin who came to stay with Sonia's family while her parents were settling themselves in America. It is not that Sonia did not see the good and bad of her parents: she did. *but she would not allow herself to act upon this knowledge.* In other words, she did with the good and bad of her parents what Elizabeth did in her sexual life—denying what she felt in view of her knowledge, dissociating, if you will. But it is the identification with her father that Sonia defended in this denial or dissociation. Later she began talking of this identification. It was the father who was house bound and who was “more neurotic than the mother." the father who was depressed, hostile, demeaning, arrogant, grandiose. and so forth. The mother was “more stable," worked hard, had friends, but she had the same contempt for people that the father had and always told Sonia that she was “above" the children in the street. Sonia’s family was “good” other families not equal to them and were therefore “not as good.” according to mother. Sonia was “better" and “luckier." Sonia could not play with other children. The truth was that Sonia was partially rejected by the children because of her personality, just as my patient, Elizabeth, was rejected by the “normal” group due to her peculiarities.

In the family there are “good” and “bad” children, but being the preferred child in a family does not preclude the possibility of that child becoming neurotic. On the contrary, the preferred child is usually extremely

neurotic. Flora's “preferred son" (she has a “good” son and a “bad" son) is perhaps even more disturbed than the rejected one who became the homosexual; both, of course, have serious problems. Sonia would be called a help-rejecting patient due to her tenacity in hanging on to her defenses, particularly her masochism (and sadism) and her need to distribute her hostility so as to maintain an equilibrium. She could also be said to be “fused” with her mother. She fears annihilation rather than “abandonment" if she is not attached to a hostile figure; this was her original fear. She needs a figure to hate or to demean or else she will turn on herself in a much more hostile manner than she usually employs toward others. She holds herself together in this way. The “fusion” is thus a way of handling her aggression. Whether we call this phenomenon fusion or dependency or, as I like to think of it, sadomasochism in the context of projective identification, we must realize that we are speaking of behavior that bears no resemblance whatsoever to infantile behavior. Therefore, to call the behavior “regressive” is simply a misunderstanding of the dynamics. To call the aggression instinctive is simplistic and misleading since all behavior could be said to be instinctive. This type of behavior, like so much other behavior, may become possible through the neurophysiological mechanisms that are “givens,” taking its shape and form from the kind of experiences the patient has in his relations with people and things over a long period of time. Each individual in this world has experiences that are similar to the experiences of others, but each

individual experience has also its uniqueness.

The need for a hate object has often been mistaken for dependency and an unresolved “symbiosis.” Kohut believes that the patient maintains himself against “shattering and disintegration” by clinging or “fusing" and Masterson speaks of “abandonment depression,” a fear of losing the object, thus the need for clinging or “symbiotic” relationship. I believe that the depression one sees in borderlines is initiated by the patient’s feeling of rejection due to the obvious need of his parents to use him as a projective object in the interests of their defense and equilibrium, a circumstance where he sees no exit and feels trapped. He develops anger but never feels that his anger is effective so far as getting himself free from the trap is concerned. His hate eventually turns to revenge feelings. And it is in the interest of revenge that he pits one person against another and is negativistic when it comes to utilizing insight. *The associations are the vehicles by which the personal experiences are revealed.* The symbols and situations in the dreams and fantasies are the means through which the implications of the patient’s personal experiences are depicted.

Several family members are involved in most cases where neurosis and psychosis evolve, and they provide the experiences that are traumatic to the patient. As time goes on, the patient begins to fear the parent’s aggression and thinks of it as life threatening. As he continues to assuage their guilts, he

becomes attuned to the total sadomasochistic pattern. His revenge feeling beings to take form. As his own guilt mounts, the homicidal and suicidal impulses become more intense, and the patient fears annihilation if he is separated from a hostile object. This is not, however, similar to the clinging of an infant; it is rather the conditioned pattern of sadomasochism, which is quite a different matter from the early mother-child relationship. It is certain that one must work with borderlines using projective techniques, and one must wait until the patient decides to pick up on a given aspect of the problem before the working through can be accomplished. The analyst may have pointed up a problem, using the projective technique, six months prior to the patient's mentioning it; yet the analyst cannot begin on the analysis of this particular aspect of the problem until the patient decides to give the go-ahead signal. This *waiting for the patient to pick up a trend for work* is different from how one would work with a neurotic patient, where the therapist might put together a construction and then *suggest* an area of work.

How are the patient's defenses and his acting out related to the family matrix? The parents' fantasies are "connected" to the acting out. For example, in my 1973 book (p. 46) I mentioned Freud's paper "The Psychogenesis of a Case of Homosexuality in a Woman" (1920). I pointed out that the "family system" was involved in this case. The father and mother had emotional investments in the daughter's homosexuality. The father loudly protested the "badness" of the problem (the girl's acting out was in part an aspect of her

revenge), *but the mother was complacent,* almost showing approval of the girl's conduct. The picture of the flamboyant homosexual partner, the seductress, the exhibitionist, was a prominent aspect of the picture, a focus for much concern to the parents. The homosexuality was in truth a "family affair." I can say the same for the homosexuality in Flora's son. The instigation of homosexual behavior is definitely a process in the family that has meaning in the interlocking defensive system of Flora and her first and second husbands. The associations of Flora in her sessions and aspects of her dreams make this family pattern obvious. The present husband ignored one son's homosexual relationships early on and denied that they existed; just as he ignored the lump in Flora's breast, denying its existence. Two therapists noted that he also fostered both sons' drug habits and their failures. In one son's fantasies there are references to these experiences with the parents and the resentments inflicted in the associations with respect to insight and/or learning. Here are some of the factors contributing to associative linking, which Rosner (1969) feels are present in all patients: (1) the need to complete an incompleted task (the Zeigarnik effect), (2) the factor of recency. (3) the Hoffding function, i.e., the selective effect of similarity,[15] (4) the law of contiguity. The latter refers particularly to "manifest content." The "latent content." Rosner believes, is more closely related to the laws of similarity, requiredness, etc. Since sheer contiguity is not a basis for memory the latent content must be coupled with "intrinsic similarity." Analysts could view the

recalled contiguous event as covering over the important event by displacement, substitution, screen memories, etc. “Thus analysts would aim to remove the anxiety of a defense so that the event could be associatively related to the “main point of focus in terms of similarity requiredness and the like." Interpretation aids the recovery of “real memories" rather than “screen memories" and “paves the way for the patient to face the *affects* he has been avoiding through defense." (The borderline patient is loath to experience certain “affects" or “feelings" and defends against them strenuously. He is often willing to admit his knowledge on an intellectual level, but he denies feeling.)

In this chapter we have touched upon questions of theory and technique that confront all therapists in their treatment of the borderline. Thinking through these different viewpoints and focusing on a rational theory helps the therapist in his work with these difficult patients.

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Notes

12 However, many of my borderline patients have achieved great status in academic and social life, but their activities are not what they could he for their abilities.

13 I might mention that the “quote" in this 1960 paper about interlocking defenses is from my lecture notes and an unpublished paper delivered at the Postgraduate Center for Mental Health in New York City in November 1953. Von Domarus made some comments to the effect that the ideation I was describing in the borderline was in fact paranoid; he did not mean that the patient had an organized delusion that was daily motivating but that the patient tended toward paranoid thoughts in times of stress or anxiety.

14 Zeigarnik postulated that memory for incompleted tasks is more vivid and persistent than for completed tasks. We may postulate that where frustration has caused inhibition of action, this may be felt as an incompleted task and may account for the patient's intrapsychic conflict and his repetitive fantasies. It may also be an impetus for seeking treatment.

15 In the interpretation of dreams or fantasies, for example, we use the “just as” formulation of Freud in understanding identifications with figures in the dream, i.e., the similarities with the patient’s personality that are represented by the people in dreams. This principle is also important in the use of projective therapeutic techniques that necessitate the use of similarity in focusing on the problem of the “others.”