THE TREATMENT PROCESS

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The Treatment Process

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The Treatment Process

Although there is a general pattern that applies to all borderline patients, the uniqueness of each individual is what makes the treatment process so interesting. Recently one of my former patients who had been in treatment with several therapists before me and whom I had seen for five years and then referred to another therapist when I went to Mexico for six months returned to me. It was interesting to see that in the four years that I had not seen her she was considerably better than when she had been with me. When she came to me, she had many self-reference ideas and many other paranoid types of reactions. For example, she would tell no one where she lived and would not even let my secretary know her address. She had many locks on her doors. Now she had changed. She had moved to a new address, and when I told her that my secretary would need her address and telephone number, she gave it to me readily. She was angry with her last therapist, saying the therapist had not helped her in any way. She had worked on her own but recently had made a suicidal gesture and had been hospitalized for a few days. She did not want to destroy herself, but she felt she might if she could not break her pattern of idealizing some man at work and then thinking that he was communicating with her in relation to a possible affair, only to be

rejected later on by the man who would complain that she was molesting or pestering him. This obsessive clinging to the feeling that the man was sending her love messages was a masochistic fantasy where she was tortured by the possibility that she would be doing something that was driving the man away from her.

Perhaps one can say that the patient who has an obsessive idealization defense that is accompanied by paranoid projections (particularly self reference stimulated by current events upon which the patient projects) is one indication that the treatment process will last for twenty years or more. This is not to say that the patient will be immobilized, for the patient can work, enter marriage, have children, and so on. There will, however, be difficulties in interpersonal relations, and in some instances the individual will have to leave work situations every year or so until the core problem has been worked through to a point where direct and verbalized transference can be tolerated in the interpersonal relationship with the therapist. This process can take anywhere from seven to twenty or twenty five years. Such a patient are my patients Sonia, Harriet, and Flora, whom I refer to often in this volume. It is my thought that the dynamics of borderline cases may be more evident if I discuss in this chapter the more resistive types of cases, those that are closer to psychosis, and who may be in treatment for as many as twenty years or more.

Working Through

We know that in "working through," understanding the problem is not enough. The patient must be willing to tolerate the anxiety of changing his behavior. If we have resolved small parts of the problem and he has worked them through in relation to the anxiety, this helps in the working through of the next part. During problem solving if we deal with pieces of problems, aspects of the whole, then finally we can put the puzzle together much more easily. But it is almost impossible at any given time to make a statement about the "complete whole." As Rosner (1973) points out, the "psychological field" is ever changing, the configured structure of the field is fluid, and new ideas (or old ones, for that matter) can be aroused when they are related to a preceding thought in the process of association. The whole process, as we have suggested, advances in a geometric pattern. Once the new ideas, which may merely be a combination of old ideas put together in a new way, are in effect (i.e., are integrated), then the mental constellation changes into something new, and behavior changes at the same time that this process takes place in the mind so that the person is never quite the same again. (We must remember that this "law" applies to the infant's learning, experimenting, and integrating as well as to the learning of adults.) With the patient who has an emotional problem it is his anxiety that impedes his learning. With each new experience the mental "schemas" change, and the individual is different from what he was before.

We must not forget that the patient changes his behavior in relation to other people. Thus he is in a group process as he “works through.” He learns about his transference reactions in the analytic situation, not only his reactions with the analyst but with others as well. He learns how the behavior of others sets off certain reactions in himself. The analyst is working in relation to the transference in a group process, and his knowledge of the patient comes from two sources—(1) what he observes in the individual and group sessions and (2) what the patient tells him about his relationships at home, at work (or at school), and in his leisure-time activities.

When the borderline patient changes as we work through the pieces and parts of a problem, these changes can be so subtle that they do not show externally until a considerable time has elapsed. The borderline patient is resistant to the stimulation of new learning, because of the *guilt* that it evokes in him, the *fear* that he experiences in stepping out of his neurotic role, and the negativism or anger that he employs in relation to the transference figure, the therapist, and to others with whom he has transference reactions. The pleasure of autonomous behavior in areas that have been prohibited is at first a frightening experience, and he must learn to give up his masochism piece by piece as he goes along. The sadism (his revenge feelings and his vindictive behavior) is the last aspect of the problem to be worked through, for they are the most hated and most denied parts of his personality even when they are obvious.

The Initial Phase

The borderline patient, in spite of what many investigators think, has a concept that "something is wrong." With an active questioning in the initial interview the therapist can begin to be in touch with the patient's "observing ego." One must then try to ascertain what aspect of the total problem the patient is willing to tackle with his observing ego and where he is willing to make a change in his behavior in the immediate future. This is the part of the total problem where one must focus initially and work through to a successful conclusion. Having had this minor success, the patient goes on to another minor success and another until a more global working through finally takes place. In the beginning the patient's ideas concerning his dreams and fantasies are elicited and used as his associations. The borderline patient does feel symptoms to be "ego alien," and the "Zeigarnik effect" motivates him to go on to more satisfactory solutions than what the borderline state affords. We might note in our record for the first session what aspect of the problem is available for a cooperative focus. Joint work between the therapist and the patient can begin in the accomplishment of a "small gain." In the initial session with one patient I recorded for example, that the young man in question, Jerry McDonald, had obsessive symptoms that bothered him, but he also had a fear of what damage his early life experiences might have done to him. He verbalized wanting to work out his perfectionistic ways and why he felt a person is all good (idealization) or all bad (hostile); or, in other words,

why if he sees that a person has a flaw, does he reject the person after having idealized him (Wolberg, A., 1973, pp. 195, 199). This, however, is a major problem that can be talked about but cannot be taken as a small focus to begin with. Jerry feels immobilized, but he feels he is not really inadequate even though he acts inadequate at times. On some days, he said, he gets no more than one hour's work done in the whole day. This might be a specific area upon which to explore what actually happens on such occasions. What are the steps that lead up to such a day? He is not immobilized every day but only on certain days. Think of this problem as if one were going to do short-term therapy. The important point is for the patient to have success working in a circumscribed area. We might say that the focus (F) is to understand the circumstances that lead up to a "bad day." What happens? What are the incidents that precede a bad day? What interactions does he have with people and who are the people that create in him the kind of anxiety that is immobilizing?

Harriet Hamburger, too, had the feeling of being immobilized. She came into therapy at the insistence of a social worker, Mrs. S, who was employed in an agency where the Hamburgers had gone to inquire about adopting a child. Harriet and her husband were refused a child based on what Harriet inferred were psychological reasons. They had seen a psychiatrist who referred them to me. When the Hamburgers came to me in November 1950, Nelson (the husband) was working and attending college at night to acquire an

engineering degree. He felt that he had no problem and was not interested in therapy despite the rejection for a child and Harriet's inferences. He let me know that he had no desire to go further. However, he was willing to take a "quick" look at the Rorschach cards. He noted that he had had a Rorschach test in 1941 but was vague as to why, just stating that it had something to do with school.

In the remainder of this section I shall present abbreviated illustrations from Harriet's case history, plus very brief comments about Jerry McDonald where applicable, to point up our discussion at the outset of the section.

11/14/50—Nelson Hamburger's Response to Rorschach Cards

1. A grotesque butterfly.

2. A bat.

   A torso.

3. Two comedians on the stage—

   Dancing.

   Holding a muffler.

   Slapstick comedy.

4. Vulva on top.

A grotesque dancer.

A bear or gorilla.

5. Bat feelers and everything.

6. Leaves me cold.

A bear rug.

A penis.

7. Two girls picking at each other; making tongues at each other.

8. Two mice monsters—

Climbing

Hard job.

On the rocks.

9. A nice design—testicular.

Clouds—I like this.

10. A something with an arm coming to a divide (blue crabs).

11/14/50—Harriet's Responses to Rorschach Cards

1. Two elephants and two something else—some animals.

2. Bears kissing; paws dripping blood.

Two elves.

3. Two men in full-dress suits dancing around a pot.

A headless person or animal.

4. A man with tremendous boots—apelike face, hands small.

5. A bat.

6. A vulva and a penis.

7. Figures and persons in airplanes.

Also plumes and tails.

8. Two rodents holding on to the top of a tree on a mountainlike cliff.

9. Two people back to back.

A fierce storm.

People on the bottom of something.

10. Faces in the pink part.

Spiders holding on to green birds.

At the same session Harriet, at my request, made a drawing of a man

and woman (see Figure 2). After she completed the drawing we discussed it.

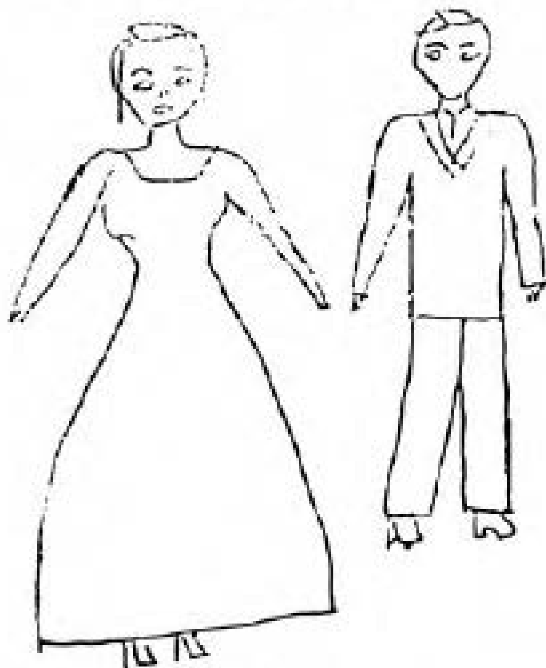

Figure. 2.
Man and woman drawing. Harriet Hamburger, November 14, 1950.

Pt. The man has short hands.

Th. What are your associations?

Pt. Maybe I'm castrating him.

Th. What is your next association?

Pt. I feel like him. He was passive—dominated by wife—castrated. I feel castrated. The woman is dominant. The absence of a relationship with my father and the possessiveness of my mother make me oppositional to her—and secretive fighting rather than an open anger. I was full of anger but a conforming child.

11/16/50

Harriet says that she must please and be liked; she feels uneasy if she is not needed; she verbalizes with friends and husband to allay anxiety; she cannot refuse the demands of others; she must help others to figure things out if they ask her. She cannot say "no" to people even if what they ask of her is inconvenient. She often has a fantasy that she has a kind mother; she talks of feelings of hostility with guilt. She says she plans what she will say in the sessions. She asks permission to talk the sessions over with her husband. In the previous session she spoke of a girl who was angry at her husband; in a social setting this girl made a terrible spectacle by expressing her anger at her husband.

Patient says that she is frightened of men and mentions a man in the apartment house. He just returned from a mental hospital; he is a paranoid and she is frightened of him. He never does anything to her, but she is frightened to meet him.

Patient describes her relationship with women. She is passive, dependent, she is drawn to aggressive women, women who express their

aggression through talking and acting efficiently—she does not see these women as overtly hostile. (This is like her mother. I

Patient says she has feelings of frustration and hostility when she tries to do things—feels inadequate. She really does not want to do anything.

She asks therapist to teach her to say “no” so she can use her time the way she wants to.

Both Jerry McDonald and Harriet Hamburger asked for help in a direct way about a certain problem. One can assume that these pleas have a defensive quality but even so, one can nevertheless explore them, for while they cover deeper problems, they are areas that the patients are willing to explore. Harriet talks of phobic and paranoid traits, hysterical qualities, and intense hostility, while Jerry talked of a “tearing at” characteristic of an obsessive nature. Both spoke of negativism, and of dependency. Harriet is drawn to aggressive women. Jerry is seeking a father who is controlling, and he wants the therapist to be someone he can depend on. He wants to unburden himself on someone who is wiser and helpful. Harriet wants help in saying “no” to people who make demands upon her and whom she feels she must obey compulsively. Each say that they have negativistic feelings. In Jerry’s case there was a vague reference to needing a man—too much—or wanting to be attached to a man.

A few sessions after the first week Harriet revealed her depression by having a dream of two caskets with one child (or teenager?) in each casket. The atmosphere was bleak, barren. Two parents were somewhere near in the dream. She also had a sexual dream, and her associations were to someone who was a pervert. She asks the therapist what she would think if she discovered that Harriet was a pervert?

12/1/50

> Harriet reports a dream about her grandmother, but she cannot remember the dream. She thinks her grandmother was dead, and she felt terribly, but not sure. Her associations were that when she was 5 years old, she visited a neighbor who told her of her son who was negativistic and if you want him to do something "just tell him the opposite." Patient was playing with the little boy and wanted him to do something, so told him the opposite. He did. His behavior was some misdemeanor (not so but thought of as sol. Reminded her of her grandmother. Her grandmother blamed her and humiliated her before the family. She could not answer back and defend herself. She felt hurt, maligned and helpless.

Patient uses these memories as masochistic fantasies and sometimes looks for slights. The grandmother was the mother's mother. Patient feels in a masochistic position in the session. Takes comments of therapist and uses them masochistically.

12/5/50

Harriet talks of her previous dream—an anxiety dream about her

grandmother. She says she never could stand up to her grandmother; she must have been afraid of her. *[Transference fears.]* She reported three dreams:

> Dream: She was working in a large office. She had ability and had come to the attention of the executives. But she was supposed to be let go. She was standing before a girl at a desk, humble; she was being let go because there was no more work to do. *[Fear and wish and transference problem, rejection fear.]*

> Dream or fantasy: Something about her needing something, perhaps from therapist and she was told, "I can't help you now; you'll have to wait." *[Rejection.]*

[Therapist asks about the office where the patient works. There is a new woman in the office; apparently this causes her anxiety. She does not know how to deal with this new woman.]

> *Dream*: A certain area in Brooklyn. An unknown man in the office. She thinks of her cousin. (Her cousin has three children; she adopted a boy. Cousin and husband complain about the behavior of their children. *[Patient doesn't like to hear of these complaints]*) In the dream there is complete desolation, no human sound, a musty odor—some pestilence must have been here. How did the people move out so quickly? Then it was like a Catholic funeral parlor, but there was a man and a woman, a Jewish couple. A priest had said something about children; the man and woman rushed around the corner. There was a coffin—a man and woman were close. Were they husband and wife?

[Fighting and arguing and rejection and depression—these are the mood feelings.] She denies having any feeling—she is like her mother-in-law. She detaches *[dissociates ?]* from her feelings but she is hostile. She feels guilty

about her hostility but she cannot help feeling that way. She acts with her husband the way the mother-in-law acts with him. There is conflict between them.

12/8/50

Patient says she belongs to that group of intelligent individuals who can express neither grief nor anger; her mother-in-law is one of those people too. One woman told her mother-in-law to leave and not come back again. Patient says her mother would be very angry at the mother-in-law; husband was the peacemaker. Most children had gained their independence, but not her husband. Patient tells about how she blew up at one of the tradesmen *[safe]*—"I wanted to attack my mother-in-law. I was very nasty *"[guilty].*

> *Dream:* My brother bought a dress that cost $60 for his wife (in reality this was for a wedding). My brother and I were in bed; he had his head against my breast. I said "He's very reticent about hurting me"; something about sexual relations hurt *[sadomasochism].* Her associations were that her mother and father were always fighting, they are always going to separate; once they had a big row and he went to live with his mother.
>
> "I was ashamed; almost everybody knew about the affair; I was more sympathetic with father; mother had been abusing him; she would go out to play cards and neglect him. My father was the appeaser; she would tell everybody what a beast he was; she wanted people to agree with her that she was abused. He would come back and then shower her with gifts; she said that he was with another woman." This was a pure fantasy with her (the mother), but she kept insisting that this was so. He said to her that she had wronged him so that he could go ahead and wrong her by having an

> affair. He gives her the money; she holds the purse strings; father asks mother for money. She is stingy. Father would say he wishes he could have a good steak; mother would not give them any extras to make them happy —only necessities. She would always say that she served a nice table and she is a good cook—this is true. Father feels deprived; he always would indulge himself when he could.

The patient feels in the session that she is deprived; she has transference feelings that I do not give her enough. Actually, we have not focused on anything other than that she cannot say "no," and she is angry about that. I asked if she felt her relationship with her husband is similar to her mother-in-law's relationship with her son (patient's husband). She replied perhaps, but she hopes not.

1/4/50

Harriet reports having a dream: Her boss and his wife are adopting a child: I don't think he wants the child; he's doing it to please her; she adores him; he tolerates her; calls her "Baby"—father and daughter attitude. The wife appeals to patient for help. She doesn't just ask me to do something." She talks of the problem of giving presents to in-laws. She wants to give but not too expensive; her husband does not want to give.

> Dream: A box of Kotex is being exposed in a room, and I'm trying to hide it because people would be coming around.

> Dream: I have a desire for an ice-cream cone.

She has associations about entertaining company in her home—three couples. Estelle and husband; ditto Edith and Marion. Marion cried on patient’s shoulder when she had her second child; she has angry feelings toward Estelle and Edith. Estelle asked patient once why she did not discourage Marion’s confidences and use her to tell of troubles. Marion is very emotional, sometimes like a child; she shows her emotions. Edith denies emotions; secretly she’d like to express emotions as Marion does but she can’t. That evening the patient was the referee. Estelle and Edith were particularly argumentative. Edith has money but she does her own work in the home. Estelle always takes the easy way out of everything; she has professional aspirations.

Edith and patient have been very friendly; patient helped her and thus put her on the spot. She feels uncomfortable and guilty—she’s jealous. Edith will talk about Estelle to patient; Edith is caustic, hostile—then does things to regain love. People’s confidences mean very little to her; she has a sharp tongue and will reveal confidences to others. Patient has used has as a confidante. (Will the therapist act the same? She may have this fear.)

People tease the patient and her husband because they go everywhere together. One day the four girls were visiting and patient’s husband went out. Edith said, “Oh, my God! don’t tell me you let him go out!”

Edith and her husband are on the verge of divorce. Edith is pregnant and uneasy about it—thought she was going to die or that the baby would be born dead. Patient said, “I’m sure I’d never get involved in any such relationships.”

When patient left the last session she was uneasy, what is this woman [the therapist] like? How will she react [she was thinking this about therapist]? Asked how she thought that therapist would act, she said she was afraid. She thought the therapist might pity her; also thought that she would think patient very special [these were grandiose feelings].

She mentioned that when she was born her father said “A Queen was born.” Queens are special.

The first focus was on her inability to say “no.” The second (briefly) was on transference feelings; How would the therapist think of her? How would she size up the patient? Would she be giving—helpful? What was the therapist doing that was not helpful? There was some discussion of her oppositionalism and the idea that it might mean that she has fear of letting someone be too forceful or too submissive as with her mother. The focus then changed to her work situation and how she manages with women bosses and with men who are “in charge.” Along with the feelings about bosses, the discussion included the way she acted in the marital situation and how she

and her husband get along. Harriet was vague about what went on between herself and her husband but was much clearer about how she performed at work so the focus was primarily on what she could do to improve her professional chances and how she could change her attitudes at work. Throughout there were vague references to transference feelings and how she and Nelson (her husband) were getting along. There was much hostility toward her husband but, “We are glued together.” Then all of a sudden she decided that she had to get separated and try for a divorce. *Why* was hard to ascertain and she never gave any reason except to say that her husband is paranoid and a schizophrenic. They were finally divorced, and her work situation improved. She went back to school and began a career as opposed to being a secretary. She was afraid of men. Over a period of ten years she continued to see the therapist.

12/15/60

> It’s not funny; I was very backward. I had guilt about departing from my family when I got married—I felt guilty about wanting to go. When I went to work, I felt this way too. And I was unsuccessful. It frightens me; I seem to have a purposeful desire to frustrate my own ambitions. My work history is a complete flop. I am horror struck when I think of it.
>
> My mother has three children; my father is one of them and then there are my brother and me. My father was crazy about my brother; he had to have a sweater like my brother’s. My brother was a famous basketball player on the college team.
>
> My mother was central in the house, then grandmother; my father

was controlled by my mother. Nelson was not a husband to me but a competitor—and he was in competition with my father and brother; I controlled Nelson. He's a strong man, but his mother tells him when he's right and when he's wrong. He says, "She's killing me; I'm dying." My father always pushed me toward my mother; he forced me to get from her what a child would want from both a father and a mother. She represented a haven to me. I hated her, but I could depend on her. It seems to me that this is important in my relationship with men; my role with men is some kind of a caricature. I've felt threatened by the idea that I could be hostile to my mother. I've been very much like my mother in my behavior with men. And my mother taught me "Thou shalt not compete with me successfully." I'm in a state of semi hysteria while I'm talking. My father was not a father. I felt that he forced my brother and me into a hostility with my mother, pitting her against us. He showed his hatred for my brother by forcing him into an altercation with mother—mother was extremely hostile to my brother.

I felt very threatened when I thought of my mother being hostile—I mean now—not as a child. I must have been threatened, but then I did not even think of such a thing—she was so hostile, so competitive with me. It still is hard for me to say that my mother did not want me to be happy. I feel detached from that idea. My mother had a terrible fight with my grandmother. One of the things that my grandmother said was that she was going to rip the mask off my mother's face—to reveal her as the mean person that she is. That was my father's mother.

It must be that other people get threatened when they have to realize certain things about their parents. It's a woman-centered world, emotionally—what does that mean exactly? The universe centers around the strong mother figure. If you look back at the drawings I made when I first came into therapy you'd probably find that the woman figure is bigger than the man figure. I can't help but feel that this thing has a lot to do with my not remarrying yet—my father's role in the family.

I asked her to do another drawing. She said she would. She has had three disastrous relationships with men—each man being "very odd"

(neurotic) and the last man was definitely psychotic. She feels hopeless about finding someone and says she would like to go to a match-making organization. I tell her that I think she should be able to find a man on her own. She says she would rather go to a dating bureau where they serve people who are serious about marriage and where they do tests to determine who would be good for whom. She says that she heard me talk about such a service. I give her the information. She goes to the service and within three months she tells me she has found a man, a worthy man and one she can respect, one with whom she hopes to establish a good relationship. It is at this point that her analysis takes on a form of dealing with her problems in a direct fashion. It was not until seven years later (1967) that we saw changes in the patient's behavior. During that period she had "gone with" the man she met at the dating bureau for about three years. They had some difficulties making an adjustment, but both were determined to "make a go of it"—they did marry about four years after they met. Three years after the marriage, Harriet was still in treatment, but her man and woman drawings had changed (see Figure 3).

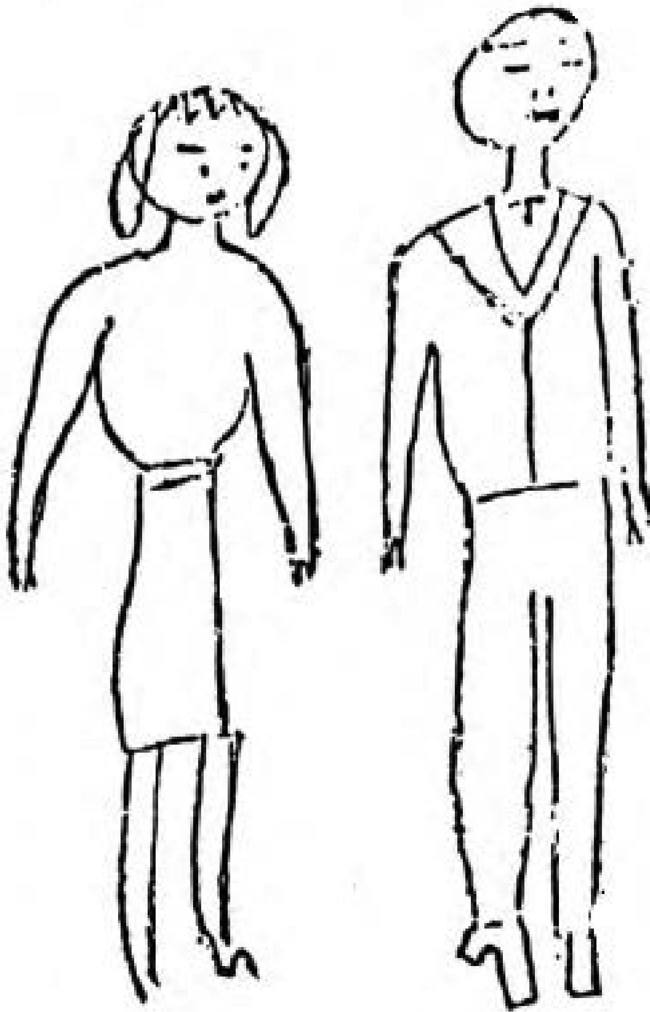

Figure. 3.
Man and woman drawing. Harriet Hamburger, 1967.

Breakup of an Idealization Fantasy

We cannot tell how long it will take a given patient to work through the idealizing and denigrating transferences, which in my opinion are related to the patient's deepest neurotic feelings. Sonia Gerber is only recently beginning to do so after thirty-two years of dealing with several therapists, twenty-two years with me. Her first treatment began in 1948. She is one of those patients who tended toward the psychotic edge of the continuum. She is one of the few patients I ever had who never married after a divorce in early life, although she has had many "affairs." She has had an ever present "hate figure" in her sister. This problem of hating some people and idealizing others that we find in the borderline patient has great significance in treatment. It is the essence of the sadomasochistic transference, and it takes many years to work through. This is the phenomenon that has been attributed to "splitting" or to the "breaking up of the object," or the inability to see "good" and "bad" in the same person, or "the inability to perceive the object as he really is," and so forth. I see this as transference, as an aspect of the patient's defensive system and as a hysterical mechanism with obsessional overlays. The aim of these hysterical or denial mechanisms, and the obsessional elements, has to do with a *denial of the identifications* and what these mean to the patient (Wolberg, A., 1973 pp. 165-166,173-174), a denial of the destructiveness (of both the patient and the parent) and the rejecting attitudes of the parents; and the patient's fear of annihilation as a consequence of parental destructiveness.

More importantly, it is a denial that the patient now, as a consequence of the identifications, is like the parents in certain ways. Such patterns must be outlined, delineated, and eliminated in treatment.

As we have said, the patient's aggression is actually a counteraggression, a defense aroused by the frustration at the hands of the parents. It is frightening to the patient, and he defends by distributing his aggression among several objects, i.e., by projecting on to these objects and being hostile to these objects, sometimes in subtle ways. These objects are substitutes for the parents. If the patient has relations with the parents the interpersonal encounters are always sadomasochistic. Actually, these dynamics are aspects of the global defense of projective identification, which is partly a defense against aggression and partly a defense against the impulses toward autonomous constructive behavior that the patient has been taught to inhibit.

We have noted that the patient experiences feelings of disgust with himself for succumbing to the identifications and fears that the therapist and others will feel the same; and often others do have this attitude toward the patient. As these feelings of the patient are given expression in various forms, the therapist should recognize them and interpret their meaning. With the therapist's help the patient gradually works through his identification conflict while simultaneously strengthening his autonomy. This allows him to shed

his sadomasochistic self-demeaning pattern, which takes many forms and has to be pointed out and worked through step by step, or piece by piece, over and over again until the whole pattern is clear. If one is attempting to help the patient toward any kind of personality change, this process can take many years in view of the denials and the projective aspects of the defensive system. Projective identification is a most complicated defense, and to work it through is a difficult task.

In working through the transference where projective identification is present, one finds that the most highly defended area is the identification with the most rejecting parent (IMRP). After Sonia had had a straightforward transference reaction to me that she could verbalize (this occurred, to be exact, on August 20, 1979, when she declared that I am "cold, ungiving, detached"), she talked of her father for the first time in a different way. She told of holding her father's penis—and she spoke of this as if it were unusual but in ordinary tones rather than with shame or excitement. She described a series of sexual incidents with her father. It was only after this that she was able to break up her idealization defense. She began to tell me the story of her sojourn with her parents when she was 9 years old to the southern part of Russia where her father had gone to work. She spoke casually and mentioned that she told it to me many times before, which was not true.

In the therapeutic process we are confronted with the transference that

is opposed to a realistic image of the therapist. In working through the transference we are dealing with the conflict of opposites; the neuroses or psychoses of the parents versus the well-being or the autonomy and creativeness of the child. In the neurosis (or the psychoses) we have the bipolar "identification with the aggressor," i.e., the internalization of the identification roles versus the self-preservation impulses of the individual, the need for "safe" neurotic adjustment versus the autonomous behavior. The defense of projective identification has supportive defenses of denial, repression, and idealization. The opposite—anger, rage, revenge, and grandiosity—are the elements that create the conflict that intrapsychically then is presented in the dual object representations, i.e., the fantasies. The projections and denials and the idealizations (the remaking of reality) account for the paranoid trend or the delusional material. We may symbolize the dual self- and object-representations in the fantasies by the following—DSRs and DORs. We must remember, however, that the fantasies are not actual memories; rather they are "psychical outworks constructed in order to bar the way to memories," and "symptoms and fantasies like dreams have a similar mental construction" (Freud, S.E., 1887-1902 [1954], p. 197). D = denial; S = self; O = object.

All of my borderline patients, when they began to work through the last phase of analysis, ushered in the period with talks of (1) some kind of perversion, often several kinds, (2) paranoid reactions (in the last stages of

working through transference the patient mentions his own identifications with the paranoid attitudes of another person and then of his parents), (3) lifelessness. (4) guilt. (5) masochism, and finally (6) sadism and hostility. The latter are the last matters to discuss from the point of view of losing such feelings and working them through. When Harriet Hamburger came into treatment, for example, she alluded in the first two sessions (in guarded and defended tones) to a possible kind of sexual perversion. What if we were to discover that she was some kind of pervert? What would I think of her? She would be terribly ashamed. There were vague allusions to people like Catherine the Great who used animals for sexual stimulation. Harriet's depression was depicted in the dream of two caskets, and her "ineptness" and "dependency" were evident in dreams of needing support due to an inability to stand on her legs without help. She also had dreams of being attached to women and wanting to be rid of her husband. She acted out by calling me after sessions to see if I were all right. When she began to work this through twenty years later, she spoke of her peculiarities at work, her suspiciousness of her fellow workers, her paranoid traits, her anger, and her envy. She likened this to her father's activities with his partners at work.

Sonia who is now working through the last stages of analysis, after having had a direct transference relation to me. says she feels she has been "sick since she was 0—really all my life." She describes herself as being depressed.

Th. You weren’t born “sick.”

Pt. I guess not—no—I wasn’t but I got that way very early in life. I seemed to be happy until my cousin came to live with us—she ruined my life.

Th. Not your parents!

Pt. Well—no—she did! She squelched me; she prevented the other children from playing with me. She said she was ashamed to walk with me on the street.

Sonia mentions that she recently met her cousin, and the cousin recalled how hostile she was to Sonia when they were children. She does not know how Sonia could have stood it. [*The direct transference reaction, which was a father transference, makes me think that the father was the most rejecting parent and that the memories of the cousin, although the experiences with the cousin were real, are being used as cover memories, defenses, to protect her from her feelings about her father.*]

Pt. She said I was jumping around too much.

Th. How so?

Pt. I was full of life and excitement. I’d go along the street jumping and skipping—happy—she didn't like that. I was interested in things; I’d stop to look at flowers—I’d sing. I was very good in school too. My cousin was no intellectual—I was.

She talks of a dream she had. She dreamt of a married couple she knew, emigrees from Russia. They are very paranoid, cannot get along with anybody. She speaks of their hostilities, their odd ways—their detachment. She *[identifying with them]* says she has been like that—no trust in anyone. She talks of her father who was sick and isolated. He had an attack, his first, one year after he came here. People had helped him get a job, but he couldn't work—he was too sick—physically—she and her mother had to work. *[She identified with her father]* “I have reproduced his symptoms, his attitudes. I have stopped working, given up, became depressed, especially since mother died. But before, when my original symptoms occurred, the phobia I did the same.” She talks of her refusal of life. She speaks of the refugee girl who is getting married *[the refugee from Russia],* the one for whom the engagement party was given. The girl will marry, but she does not love the man. She wants security and money. She *[the girl]* acts a role. Her life is a role or several roles; she is an actress, a doll. She lives through her fantasy life—the beautiful doll, ethereal—an idyllic fantasy. The girl will be very unhappy. She *[Harriet]* says that she realizes she is talking about herself—not the same kind of fantasies but someone who lived in a dream world, a fantasy world.

[I say that her realities were most difficult.] She did have the feeling that her father was jealous of her; he was a frustrated and disappointed man and although he was proud of her, he resented that she was successful so that she had to feel guilty about her own success. *[This is a theme that I introduced*

several years ago and one that the patient rejected for a long time. She accepted this idea only reluctantly but finally gave it some credence. I had pieced together this concept from some of the dreams and associations.] She notes that she can be very jealous, but she always has insight into her reactions. Her father was going to write his autobiography, she said, and he worked on it for several months. Then when she went to work for the WPA, her father "gave up his writing due to his great humiliation of his daughter being on relief." *[Sonia insists that her father told her that his humiliation over her work was the cause of his giving up writing.]* She estimates that her father was ill from the time they were in Latvia until he died. She was 13 years old when he became ill (1922) and he died in 1946; she is now 70 years of age (1979). She began with her phobia when she was working on WPA and her father had his first "stroke" one year later.

Sonia often said that her symptoms are similar to her father's. She has no physical symptoms as he was supposed to have had but has hypochondriacal ideas, and whenever she does have a physical problem, a cold, a virus infection, or something else, she becomes extremely preoccupied with herself, fearing death, and so on. Often I find that hypochondriacal symptoms are associated with perverse feelings that derive from physical contacts with parents or from parents using parts of the child's body as an object for *gazing* in the interest of using that part as a sexual object. The gazing is associated with a sexual fantasy. If this were acted out in a different

way, it might be in the nature of a fetish.

About five months before Sonia had her first direct transference reaction with me (August 1979), she had told me that although she feels suicidal each day she does not really want to commit suicide. I told her that I realize she does not want to, and that my feeling was that she is so guilty about her success that she cannot yet allow herself to enjoy it. I felt it had something to do with her unresolved feelings about her father. Apparently on a subconscious level she took this interpretation seriously and spent the last part of the year talking about her father. It was on September 4, 1979, that she told me of the dreams about the paranoid couple (Russian refugees). In that same session she spoke of her father and mother and herself being in the southern part of Russia:

> "Where father had gone to work—there was no work for him at home." It was there that she had her "sexual experiences with her father." Saturday night was "my night with father"; it was then that she slept with father, and mother went to another bed. She would lie awake waiting for him to come to bed. She would scream: "Come to bed father!" When he would finally get into bed, she would hold his penis.

It was apparent that she was telling me of her denigration by her father. He did not look up on her as a child but something to be used. When she was much older, he blamed her for his unfinished opus—just as she blamed her sister and her cousin for her problems rather than her parents. It is true that the sister and her cousin did the things of which she accused them—the

cousin told me so.

Whether Sonia’s story of sleeping with her father is true, I do not know. When she told me the story, she asserted that she had mentioned the episodes many times before. Her “affect” was detached and “amused.” After she finished telling of the experiences, which lasted over a period of nine months, she then came back to the “emigrees,” discussing their problems and particularly their various neuroticisms, including the paranoia of the couple in her dream. No one would ever be able to satisfy them, she said, and she realized they had inordinate amounts of hostility. She then said she felt less hostile herself toward the bourgeois attitudes of the people who were at the engagement reception she attended. Toward the end of this session, she said she felt like crying; it was like “burying them.” I said a few words about how people often feel sad when “working through” their problems.

The next week Sonia came to the session full of rage concerning the matter of an artist who had lost some material belonging to Sonia. As she finished talking of the artist she said, for the first time, “My anger was all out of proportion to what the matter required. I realize I’ve had these kinds of reactions a good part of my life. I don’t know why I’m so hostile.” She had mentioned her anger previously in the sessions when she had told me about her lessened feelings of anger toward the bourgoisie and their petty competitiveness, their grasping ways, their use of others, their manipulations,

and so on. She said she was indeed describing the emigrees as well as the bourgoisie in America. I had suspected for some time that her attachment to these people had more to do with her identification with her father than for any love of the emigrees as a group. She has been very angry at the Russian government. Now she admits that there are emigrees that she does not like—some rather famous, but others she is very fond of. She admires their abilities, their brains, their guts, and so forth. It occurred to me as she talked that she has "identified" with several psychotic persons: paranoid people, schizophrenic people, and manic-depressives who cannot seem to get better no matter what kind of treatment they receive—people who have no motivation to be "well" or to be rid of their symptoms. Does this mean that her parents were very ill emotionally and did not wish to be well? Or does this mean that she has no motivation? I feel she does have motivation since she was able to have the direct transference feeling toward me and since she has admitted her identification with the persons in her dreams. She can now say "I am like that," and "I was like that," and she can say, "I am hostile but I do not know why." "People don't like me," she said, and then she says that people do like her. She is working through her feelings. One might say, however, in relation to her emotional problems, that she is working through her "identifications." We would mean by this, identification with the aggressors.

Acting Out

A basic defense in emotional problems, as has been noted, is the identification with the neurotic aspects of the parental figures, an identification that is forced on the child by the parents' use of the child over time as a projective object and the parents' denials of this defense stance. An interlocking defensive pattern gradually evolves, and then the child, as adult, begins to look for a similar social situation as that in his family so that he can perpetuate his defenses, these being felt as life saving. The defenses are accompanied by mental representation of the situations and of the conflicts that have arisen due to the anxiety created by the situations. The mental representations are subject to the kind of modification that Freud found in his analysis of dreams and his discovery that dreams and fantasies have similar dynamics, i.e., dissociation, distortions, repressions, denials, and so on.

A recent paper by MacHovec (1980) is of particular interest in respect to symptoms which can be seen to be social or family situations: "Hypnotic Recall in Psychogenic Fugue States: Two Cases." The dynamics have some similarity to borderline states. The paper illustrates, to me, the difference between the manifest and latent content of fantasies and dreams and the importance of getting the patient's associations to his dreams so as to understand what it is in the present that is similar to what was in the past. The paper also underlines the dynamics of *acting out* in relation to *guilt and the inhibitions* that were set up in the past, with respect to criticism of an

authority figure, and the consequent “splitting” or dissociation (I prefer to think of this dissociation as a form of *denial)* as a consequence of guilt with the need to act out the aggression that was held in check by *repression.* The experience of expressing the aggression by acting out had to take place in order for the individual to survive mentally. The borderline patient’s acting out patterns, however, are not as dangerous as these patients described by MacHovec.

The pioneering work of L.R. Wolberg (1952, 1980) in hypnosis demonstrated beyond any doubt that repression is a factor in acting out and in symptomatology and that inhibition had to be present before acting out would take place. This is contrary to the ideas of theorists whom I have mentioned who describe the dynamics of borderline patients.

In the borderline patient inhibitions precede acting out. The inhibitions are definitely a function of the repressions that are related to the thoughts and feelings directed at authority figures who are feared and hated and to whom the child over time has been of necessity attached for survival and thus with whom he is identified. There are many varied forms of acting out, some of which are less horrendous than others. Acting out can be a husband’s impotency with his wife, or it can be a child setting fire to the family’s apartment. It can be lying, or misleading, or an act of murder or suicidal behavior. In all cases it is an expression of aggression in the face of inhibitions

related to direct confrontation of the figure who, for one reason or another, represents authority. Thus acting out is transferential behavior in a particular form. Acting out is also related to fantasies, which are disguises and depictions of the relation with parents transposed into the current situation. This does not mean that the current situation is being misunderstood. In MacHovec's illustration, one woman who could not get along with her husband set the house on fire and then went into a fugue state. Later when she discovered her inhibitions and began to understand her symbolic behavior, she decided to get a divorce because her husband is, in fact, impossible to live with. Her neurosis was such that she could not handle the matter directly so had to show her aggression in this nonverbal acting-out way in order to bring matters to a head. In the meantime she could have destroyed herself since she remained in the burning building in a fugue state. L.R. Wolberg (1952) did the pioneer work that demonstrated the relation of current symptoms and inhibitions to current situations and the past, although the patients he worked with did not resort to such violent behavior as the woman cited in MacHovec's paper. Borderline patients do not have fetishes, nor do they develop fugue states, but they can utilize dissociative mechanisms, and denial is ever present. Acting out usually follows a feeling of having been demeaned.

An Outline of the Treatment Process

In the following scheme I have attempted to outline the treatment process in the borderline patient. I conceive of the process as having four main stages, in line with the general treatment scheme of psychotherapy outlined by L.R. Wolberg (1977). An adaptation of Wolberg's treatment scheme to the dynamics of the borderline patient includes what I have called "projective treatment" techniques for handling the projective references of the patient in the first phase of treatment, remembering that in utilizing the "other" one is at the same time outlining the patient's dynamics and the dynamics of the patient's parents with whom the patient is identified. In speaking of the projections of the "other," one would be outlining the "introjected and projected" objects (the identifications).

My ideas of borderline patients and their treatment are based on intensive study of thirty-three individuals. I have observed in them similarities and dissimilarities in the defenses in their dynamics. These patients are given fictitious names in the list below for purposes of identification in the text.

33 Borderline Patients and Their Time in Treatment

1.	Charles Bander.	6	yrs.	18.	Harold Hemple,	6	yrs.
2.	Gertrude Belan,	25	yrs.	19.	Harriet Hamburger.	22	yrs.

3.	Maurice Belk,	4	yrs.	20.	Flora O’Toole Levy,	5	yrs.
4.	Jack Bennett,	3	yrs.	21.	Seibert 0. Lachstein,	3	yrs.
5.	Doris Berman,	6	yrs.	22.	Abby Newbold,	3	yrs.
6.	Kurt Blau,	10	yrs.	23.	Elizabeth Osgood,	5	yrs.
7.	Thelma Blocker,	1	yr.	24.	Gladys Bernstein Populus,	2	mos.
8.	Mabel Claire,	7	yrs.	25.	George Frank Quinn,	7	yrs.
9.	Authur Cohen,	6	yrs.	26.	Steven Roberts,	3	mos.
10.	Seymour Daird,	7	yrs.	27.	Henry Roberts,	2	mos.
11.	Polly Freiberg,	6	yrs.	28.	Marcia Salopolas,	10	yrs.
12.	James Fuchs,	7	yrs.	29.	Gloria Steinblatt,	7	yrs.
13.	Sonia Gerber,	22	yrs.	30.	James Weber,	7	yrs.
14.	Geraldine Girard,	6	yrs.	31.	Louise Woll,	7	yrs.
15.	Ellen Fitzgerald Gloss,	4	yrs.	32.	Kenneth Wolcott,	8	yrs.

16.	Cora Schultz Jonathan,	3	mos.	33.	Lisa Zane,	6	yrs.
17.	Frances Krasmire,	4	yrs.				

Brief Therapy (up to 6 or 7 sessions)

Gladys Bernstein Populus

Henry Roberts

Steven Roberts

Cora Schultz Jonathan

Brief Therapy (1 time weekly for 2 years-42 sessions a year)

Ellen Fitzgerald Gloss

Frances Krasmire

Combined Group and Individual Therapy

Charles Bander

Thelma Blocker

Seibert O. Lachstein

Maurice Belk

Mabel Claire

Elizabeth Osgood

Jack Bennett

James Fuchs

George Frank Quinn

Kurt Blau

Sonia Gerber

Marcia Salopolas

Arthur Cohen

Geraldine Girard

James Weber

Seymour Daird

Ellen Fitzgerald Gloss

Louise Woll

Polly Freiberg

Harriet Hamburger

Kenneth Wolcott

Doris Berman

Harold Hemple

Lisa Zane

Individual Therapy

Gertrude Belan

Flora O'Toole Levy

Abby Newbold

Steven and Henry Roberts were seen for only a few sessions, and were then referred to another therapist. Henry did well, but Steven dropped out of treatment.

Twenty of the thirty-three patients I have seen through to an adequate adjustment although they still have some problems:

Charles Bander

Elizabeth Osgood

George Frank Quinn

Polly Freiberg

Gloria Steinblatt

Louise Woll

Harold Hemple

Seymour Daird

Mabel Claire

James Fuchs

Kurt Blau*

Kenneth Wolcott

Sonia Gerber*

Lisa Zane

Frances Krasmire

Marcia Salopolas

James Weber

Arthur Cohen

Thelma Blocker

*Still in treatment with the author

Some of the problems that these patients have are related to unresolved transference manifestations. In my opinion these transferences concern the relations with the most rejecting parent, and that this phenomenon has a relationship on the sexual level with those patients' perverse traits. For example, the sexual difficulties of Elizabeth Osgood, Harriet Hamburger, and James Fuchs all are related to fears of the opposite sex and their hostility and disgust in intimacies with them.

James Fuchs after seven years of treatment asked to be referred to his wife's therapist for family treatment. He did this at the request of this therapist. Elizabeth Osgood at the end of five years married and left New York with her husband, a member of the psychological profession. He found her a therapist in the state where they went to live. She made an excellent vocational adjustment but has not worked through her problem with men. Her sexual problem persisted in her marriage. A year after her wedding she "visited" with me and told me, in a somewhat gleeful tone, in a kind of competitive hostile way, that her husband was having trouble with erections. Happily, she stated that she is not the only one with a sexual problem.

Kenneth Wolcott improved in his work adjustment and in his family life with wife and children. He felt, however, that his *feelings* were stuck, *deadened* and he tried going to marathons and EST. I did not discourage these moves, and he did report some help in respect to his detachment which I felt was associated with an underlying depression from which he was never quite relieved while with me. Arthur Cohen was addicted to amphetamines and food. He was a brilliant man who used to spoil his chances by always being late with reports thus frustrating those who were waiting. He reduced this pattern considerably and began to tackle the food problem, then when his depression began to lessen, he was able to lower the intake of his pills.

It is interesting that the most detached of the borderlines received no

real help from being in the group. The group members made no impact upon the detachment and deep withdrawal mechanisms. All of these patients had a social facade and were polite, never revealing their deep hostility although this was evident in their reports of dreams. Arthur Cohen, Jack Bennett, Geraldine Girard, Seibert 0. Lachstein, Kenneth Wolcott were all such highly defended patients.

Marcia Salopolas is still in treatment with another therapist and doing well. She has an excellent work record but is functioning in jobs below her capacity. She looks for adequate work but has not found it yet.

Frances Krasmire was an addictive personality (food) who did not finish analysis and left owing me $1,000. Her husband, a dentist, did not want her in treatment and refused to pay her bill. She said he would not "yield an inch." She gained a great deal of insight into the dynamics of her food addiction, realized she had married a rigid paranoidlike person whom she felt had many of the traits of her father and mother (both of whom I had seen in treatment). The father was excessively controlling and "paranoid," using both his wife and his children as projective objects to hold himself together. He isolated himself from his wife by excessive working, but had a tight relationship with her. When he relaxed, he always remained with her for social life, and at home he would stay in her presence, harping at her as she was working around the house. His wife acquiesced in all that he wanted but fought and argued with

him over every issue. She was addicted to overeating as was Frances. In therapy Frances worked on her family relationship with her son and to a degree with her husband. She finally paid part of her bill.

Geraldine Girard, a singer, of whom I wrote in my 1973 book (p. 237), never resolved her problems. She always went to the best doctors and managed to pay them nothing. It is true that she had very little income and was in no position to go to private practitioners. She "wanted the best," however, and I was one of her psychiatric helpers who saw her for no fee. She left treatment highly insulted when I began to tackle her habit of going to doctors and never paying. I suggested that she should attend a clinic or go to the welfare department and make an application for funds. She was a refugee from Germany, and finally when she received some recompense money from that country, she gave me a token amount. Eventually she got a job in her field (with a show) and was earning about $150.00 a week. She had to leave town with the show; I heard from her indirectly on two occasions, and after that—silence. She sent messages through group members indicating that she left with a "bad taste in her mouth" and great disappointment in me. I had been the "grand perfect" person until I asked her to consider why she would not go to a free clinic for her medical services if she could not afford the specialists whom she sought out.

Cora Schultz Jonathan was in treatment a few months only. She thought

she felt better and said she was getting along well. Therefore, she left. I have heard about her only indirectly from another patient who had referred her.

These patients have been loosely grouped according to Grinker's four classifications, but since they are "mixed" rather than pure types, it is difficult to place them in either III or IV. Categories I and II seem much more definitive. Thus I have classified the twenty in only categories I, II, and III.

Category I

Inappropriate and nonadaptive behavior; deficient sense of self-identity and sense of reality; negative behavior and anger toward other human beings

Kurt Blau

Ellen Fitzgerald Gloss

Jerold Howe

James Fuchs

Gertrude Belan

Lydia Ransom

Mabel Claire

Doris H. Berman

Seibert O. Lachstein

Geraldine Girard

Steven Roberts

Flora O’Toole Levy

George Frank Quinn

Henry Roberts

Jack Bennett

Abby Newbold

Marcia Salopolas

Category II

Vacillating involvement with others; overt or acted-out expressions of anger; depression; observing of indications of commitment of self-identity

Charles Bander

Arthur Cohen

Lisa Zane

Harold Hemple

Seymour Daird

Louise Woll

Gloria Steinblatt

Maurice Belk

Kenneth Wolcott

Polly Freiberg

Gladys Bernstein Populus

Cora Schultz Jonathan

Category III

Defenses of withdrawal; little affect or spontaneity in response to social situations; intellectualization; adaptive and appropriate behavior and complimentary relationships.

Francis Krasmire

Sonia Gerber

Elizabeth Osgood

Harriet Hamburger

In other chapters a number of sessions with some of these patients have been referred to. They illustrated certain kinds of problems and resistances that occur in the treatment process. The session with Maurice Belk exemplifies projective techniques. The sessions with James Weber in Chapter 11 are related to acting out and transference attitudes. These sessions also demonstrate other kinds of resistances, such as the use of idealization and

both secretive and open hostility. The hostility includes pitting past and present therapists against each other and attempting to stimulate the competitiveness of the therapist by suggesting that one therapist believes the other to be inadequate; in this particular case the group therapist, James said, was casting aspersions on my adequacy. James was trying to get me to be angry with the other therapist rather than concentrating on his problems. Some interviews are examples of working through and other aspects of the therapeutic process.

Working through the transference with a borderline patient is a long and tedious journey. It begins, as we have said, by interpreting the interactions between the patient and others in the interpersonal relationship—the patient's interlocking projective defense. Later it focuses on the patient's attempt to involve the therapist in a sadomasochistic pattern. This usually begins in an acting-out pattern right at the start, such as Harriet's calling me twenty minutes after the session to see if I were all right. After the interlocking defensive relationship is understood, we then move to the patient's reactions to me. One is impatient with me. Another feels that I am slipshod; I don't notice things. These are projections of some of the patients' own traits that are identical with the traits of their parents. It was apparent that the patients had to tolerate these traits in the parent and to act as if they did not notice them. These are undesired traits related to each patient's identification system that have to be analyzed and eradicated. The beginning

of this process is illustrated in Chapter 11 in my interview with Seymour Daird and in the interview with Louise Woll.

The final phase of working through the transference is a direct projection on the part of the patient toward me similar to what went on between Sonia and myself when she accused me of being cold and detached—two traits that she knew very well and later admitted that I do not possess. From this direct encounter, Sonia had dreams. In her associations to the dream she recognized her identifications, first with the individuals in the dreams and then with her father—the parent who had rejected her most but whom she was zealously defending, projecting his (and her own) coldness onto me (see p. 2571. While it took many more months to work through her thoughts and feelings, this was the final step in her analysis. It is true that borderline patients are difficult to treat and that countertransference problems often make it necessary to transfer the patient to another therapist, but if we persist with those who stay with us, we can work through the transference and resolve the basic problem.

The following outline indicates a schematized way of looking at the four phases of treatment with the borderline patient.

The Four-Part Treatment Process

Phase I

Objectives (Establish a Working Therapeutic Relationship)

1. Let the patient know under what circumstances he can be helped.

2. Show him that he is understood (reference to his positive values and some of his inhibiting patterns).

3. Show him he will not be ridiculed—not by talking about it, but by having a respectful attitude toward the patient as a human being who deserves consideration.

4. Decide with him where to begin. What area of the problem can be dealt with first?

5. Define a tentative goal. This must be done in the context of the particular patient's defensive system. The goal must relate to the total problem, but one selects a partial goal having relevance to the total problem, that can be attained within several months period.

6. Clarify misconceptions about treatment.

7. Orient the patient to an understanding of the treatment process.

8. Create an understanding on the part of the patient that neurotic

mechanisms can be "set off" by anxiety and that they are not "in operation" all of the time, only in certain kinds of situations.

Therapeutic Tasks

1. Draw attention to mechanisms of defense—detachment, withdrawal, the dynamics of masochism, "acting out," hysterical mechanisms —by using the frame of reference of the "other" in the interpersonal relationship so as not to create anxiety-provoking confrontations that increase anxiety and help to perpetuate the patient's patterns.

2. Help the patient to understand that defensive behavior operates in the interpersonal relationship.

3. Help the patient to identify the destructive (sadomasochistic! aspects of "acting-out" behavior, particularly masochism (self-destructive behavior). Leave interpretation of sadistic behavior until later phases but not denying this if patient brings it up—merely accepting it as a possibility. (Do not use words like "destructive"; merely outline the behavior.)

4. Emphasize that "acting-out" behavior occurs in relation to *anxiety stimulated by repressed feelings, thoughts, or fantasies* that arise in interpersonal encounters.

5. Emphasize that neurotic symptoms such as somatizations (conversions), headaches, bodily sensations, numbness, or feelings of extreme tension occur as a consequence of thoughts, feelings and fantasies that have been stimulated in interpersonal

relationships but which have been denied and repressed. (Use the “other” at first in this kind of interpretation.) It is assumed that thorough physical examinations have established the fact that there is no real physical reason for the symptoms.

6. Show that there is a relationship between “acting-out” behavior and behavior of the parents who stimulated the behavior originally. (Use the “other” for this kind of interpretation at first. The “other” being the parent. Point out the behavior of both parents and others who are in parental roles.)

7. *Point out denial mechanisms* of parents and others with whom the patient has been in a relationship; also, their angers, their hostilities, and their "good” points, if they have them.

8. Delineate the frustration-aggression motif. (This is a sadomasochistic mechanism based upon an adaptation stimulated by the parents' use of the children as “scapegoats." To relieve their own neurotic anxiety, the parents force the children to act out certain “roles” that complement the neurotic needs of the parent. Inhibition of certain normal impulses in the child must be put into operation in order for the child to act out the neurotic roles. Stress the fact of inhibition of normal impulses first and wonder about this, finally exploring the dynamics. The sexual side of this problem reveals itself in thinly disguised perverse activities of the parent with the child. Sometimes these blended with rearing techniques and were rationalized as important for the child.)

9. Explore the development of neurotic and/or psychotic behavior patterns and discuss the inhibition-guilt-aggression constellation.

Take as much history as possible in the first two sessions and then wait for the rest to unfold.

10. Handle the anxiety and the defenses of the patient when the therapist does not accommodate himself to the sadomasochistic scheme of relationship. (Use “others” as illustration first so that the patient will see that not conforming to the “other” creates anxiety in the patient and in the “other" as well. Delineate the anxiety behavior of the “other.”)

11. Take notice of the normally assertive creative behavior of the patient even when it is expressed in the minutest form.

12. Take notice of the patient’s efforts to involve the therapist in his sadomasochistic pattern and point out that this would be defeating the therapeutic process.

Technical Processes

1. Encourage the verbalization of anxieties about feelings, fears, hopes, rages, jealousies, and revenge feelings in order to undermine acting out, somatization, and other hysterical symptoms.

2. Encourage verbalization of feelings about therapy and talking of “fears” or “hopes” or “feelings of disappointment” insofar as they are related to fantasied ends.

3. Interpret all information not by confrontation but by *accenting certain aspects of the patient’s verbalizations* and through the use of *projective therapeutic techniques:*

a) Explore by *accenting certain verbalizations* after asking questions aimed at pointing out patterns in the interpersonal relationship; exploring the feelings and motivations of the "other" person in the relationship in order to point out the neurotic patterns or the character patterns of the defenses of the "other" person.

b) Let the patient draw inferences: "I do this too." The therapist should not confront the patient with defensive behavior that he is vehemently denying—merely emphasize by repeating the words of the patient. The patient can then deny or accept the ideas as he identifies with the "other."

c) Explore fears of acting out. Show the behavior to be complementary to the "other" person in the relationship.

d) Accept the projection of feelings onto the therapist, and explore the nature of the projected feelings by asking what the patient thinks, what the therapist feels and why (usually these projections are related to guilt and anger). What will the therapist do? (Transference projection.)

e) Use dreams to underline, accept, and explore *interpersonal encounters* and to delineate incidents of the day that caused anxiety; also to explore neurotic patterns in interpersonal relationships, first the "other" person or persons in the relationship and later the patient—if he can tolerate this.

f) Use "attitude therapy" to make the connection between *feelings* and *defenses* (attitude therapy is worked in the context of the interpersonal relationship). This can be used first as a

projective therapeutic technique; i.e., using the “other,” then transferring to the patient when he accepts the basic propositions inherent in the dynamic interpretation. Explore attitudes and feelings of "others" and how these affect their behavior.

4. Provide for the administration of drugs when anxiety is too intense. (The drugs help repress the paranoid mechanisms and the elation and depressive mechanisms that interfere with the interpersonal relationship.)

5. Push certain therapeutic goals into the future, recognizing that, at present, they would cause too much anxiety.

6. Consider using hypnotherapy as a technique in the first and second phases of treatment when resistance is great and passivity and “identification” are so pervasive that it is difficult to handle the interpersonal relationship another way. Hypnotherapy employs basically projective techniques.

7. Consider using behavior therapy techniques, either by the therapist or by referring the patient to a behavior therapist who works concurrently with the psychotherapy. Behavior therapy is helpful for phobias, ruminating, inhibitions, etc.

8. Use imagery-evoking and forced fantasy techniques when indicated.

9. Do role rehearsal through verbalization.

Resistances (Defenses)

1. Controlling tendencies, obsessive rumination, compulsive mechanisms, concealing and denying, fabricating, compulsive talking, rapid shifting of defenses.

2. Masochism (guilt, fear, and appeasement).

3. Detachment.

4. Sadism (hostility and aggression).

5. Deluding or “trapping” the therapist into untenable positions. Making the therapist feel guilty.

6. Repressing by “tuning out” the therapist—selective inattention (withdrawal).

7. Secretiveness about neurotic mechanisms.

8. Attempting to throw the therapist into a nontherapeutic role.

9. “Ego shattering" (dissociative and repressive hysterical mechanisms related to guilt, fear, and anger).

10. Acting out.

11. Paranoid feelings or mechanisms.

12. Fantasies that are repressed but activating.

13. Depression.

14. Overactivity.

15. Derealization.

16. Depersonalization.

Phase II

Objectives (Establish a Working Therapeutic Relationship)

1. Identify the neurotic and/or psychotic behavior patterns.

2. Show that (neurotic and/or psychotic) patterns are repetitive and defensive.

Therapeutic Tasks

1. Recognize that anxiety stimulates the neurotic and/or psychotic patterns.

2. Discover what kinds of situations arouse anxiety and discuss the similarities in the various situations.

3. Recognize that fantasies are defensive and are organized by the patient in times of stress and anxiety.

4. Attempt to identify neurotic and/or psychotic behavior as "odd," "inappropriate," "self-defeating."

5. Analyze masochistic behavior: beginning with interpersonal encounters

and leading to fantasies.

6. In the beginning emphasize *pieces* and *parts* of defensive behavior by repeating the phrases of the patient that refer to defenses.

7. Do not ask *why* questions—only *what, when, how.*

Technical Processes

1. Use projective therapeutic techniques when anxiety becomes too intense or when the patient has setbacks.

2. Analyze dreams.

3. Point out transference operations by repeating certain phrases of the patient and by asking questions about feelings toward others. Begin transference interpretations in the interpersonal relationship with others; refer to feelings *with others* and the feelings *of others* in interpersonal encounters that relate to transference. Delineate the fantasy associated with the transference feeling. Analyze feelings.

Resistances (Defenses)

1. Attempts to fend off therapist by detachment, attack, or making him feel guilty; i.e., sadomasochistic maneuvers.

2. Depression.

3. Anger.

4. Repressions and other defensive operations, such as dissociation, denial, undoing, appeasement, projection.

   a) Unwillingness to give up repressive countercharge.

   b) Reluctance to renounce symptoms.

   c) Transference resistance—an effort to evade recollection and a reenactment of sadomasochistic experiences.

   d) The need for punishment arising out of the demands of the transference.

   e) The repetition compulsion: the need to repeat transference behavior.

Phase III

Objectives

1. Pointing to the neurotic responses and analyzing the situations where anxiety sets off neurotic behavior.

2. Pointing up the patient's incentive for change.

3. Supporting the patient's efforts to tolerate the anxiety that drives him back to projective modes of operating.

4. Analysis of the defenses that inhibit the patient's creative and autonomous behavior and tracing the roots of such patterns.

Therapeutic Tasks

1. Dream and fantasy interpretation through free association.

2. In the instance of projection, asking for associations to the behavior of the “others.”

3. Moving from projection to the direct behavior of the patient when the material of the session seems to indicate this.

4. Helping the patient to adjust to the peculiarities of others with whom he wishes to live without reacting transferentially to their behavior.

5. Promoting self-esteem, self-actualizing, and guilt-free behavior.

6. Analyzing the transference and indicating its relevance to social adjustment.

7. Handling what has been called the “mourning process,” the “separation anxiety," “the loss of object."

8. Begin the analysis of aggression.

Resistances in Patient

1. Resistance to abandoning sadomasochistic objects.

2. Resistance to normality.

3. Resistance to activity through own resources.

4. Resistances to giving up defenses: inhibitions, identifications, denials, guilt, anger, revenge feelings.

5. The dread of loneliness and isolation that occurs before the aggression is analyzed.

6. Continue the analysis of aggression and delineate the relation of aggression to inhibition, sadistic and revenge feelings, depression, apathy, etc.

Phase IV

Objectives

1. Terminating therapy.

2. Promoting patient's autonomous and self-actualizing behavior.

Therapeutic Tasks

1. Leaving decisions up to the patient with no analysis of anxiety but in the expectation that the patient will do this analysis by himself or in the session.

2. Analyzing sadomasochistic behavior when necessary, i.e.. when the patient is blocked in self-analysis.

3. Analyzing transference.

4. Analyzing defensive resistance when patient is blocked from doing so.

Resistances in Patient

1. Continuing mourning and depression.

2. Difficulty in working out identification with the most rejecting parent.

3. Anxiety over confronting hostility and sadistic behavior.

4. Hanging onto shreds of guilt.

5. Anxiety over forward moves—fears of assertiveness.

6. Fusion of sadism and assertiveness.

The last two phases of treatment with the borderline patient deal with the transition from the projective defense (the projections and the displacements) to a major emphasis on the *direct transference.* The *depth of the hostility,* the problem of *fear of the transition,* and *the degree of the hurt* the patient feels at having been used and abused and rejected by the parent (parental rejection has a devastating effect upon the individual), these are the last aspects of the treatment that the borderline deals with from the point of view of working through. The patient has gotten to the point (1) where he can tolerate the anxiety of separation from the sadomasochistic object, (2) where he knows he has felt devastated by hurt, (3) where he understands that in the competitive world people injure other people, and (4) where he knows that in his relations with peers and with authority figures he can easily re-experience the hurt and angry and fearful feelings he had with his parents. In the

transition period he can talk directly about these matters, but he still reacts in an emotional way to situations that arouse his anxiety. When we reach this point with many patients, the analysis is never finished because the patient feels better and leaves.

From the metapsychological point of view, depending upon one's theory, one could say that the patient has separated himself from the "pathological introjects," or from his "identifications with the aggressors." Or perhaps we might say that the patient's "observing ego" has taken into account the operations of the "pathological internalized object relations" (what I have called the "identification systems"). Some might say that the patient has made up certain "ego deficits" or that the analytic process has created the milieu in which the ego deficits can be made up (the appropriate ego functions have been instituted). Others might say certain developmental defects have been corrected. The patient has overcome his "developmental arrests." He has analyzed and seen how his "pristine or archaic psychic structures" have interfered in his personality structure and have impeded the development of various "ego functions." He has undone the "fixations" that have kept him tied to ''early objects." Or one might say that the aspect of his superego that is tied to his id has been separated out, and he is now in control of his impulses. His ego has been formed and strengthened and has developed boundaries so that he has control over his id impulses. The split superego has been repaired. The ego functions have been restored. The splits in ego states

have been cured so that he can now see the “good” and “bad” of objects.

Actually, the patient's problem is not entirely worked out before he has dealt with his deepest hurt—that of the rejection by his parents and his feelings about their manipulation of him and their disregard for him as a person in his own right. The patient at this point is “better,” however, so that he can live in some kind of semi comfort. He avoids the last piece of therapy that has to do with the analysis of deep fears of annihilation that he has had from early childhood. He has understood (II his identification with parental figures and (2) the relation of identification to his patterns of acting out; (3) he has been able to control his impulses for acting out in large part; (4) he has readjusted his sexual life to a certain degree, but he still may have the residuals of his sadomasochistic sexual feeling. He cannot rid himself of the lack of feeling during certain periods—the cutting off of feeling at a certain point. *He* may still be afraid of the vagina, or *she* may be able to have orgasm only by manual manipulation, but defense against the ability to feel enjoyment has been broken. The patient is aware of sexual stimulation from some minor perverse activity or thought, and there is no longer the need to hold back the feeling of pleasure. But the patient has made more normal relationships. He wants to be with more normal people; he has given up most of his sadomasochistic peers. Certain depressive elements persist. The inferiority feelings have not been completely dispersed, but the patient finally says in an open way something to the effect that he recognizes himself as a

person, a separate person if you will—but more significantly a person different from his parents. He accepts his own identity, but he will still be excitable and easily hurt in intimate relationships.

The man and woman drawings done by Harriet Hamburger show among other things that it took her seventeen years to reach the third phase of treatment (see Figure 3, p. 255). It is in the third phase of treatment that the working through of the transference and its relation to the patient's most rejecting parent begins. For example, Sonia recently said that when she was a child she had three fears: fear of being smothered, fear of leprosy (rotting away of her body), fear of the end of the world. She related this to her subway fear, her phobia that began in her twenties when she was confronted with being feminine. She said that although she had fears of sex, she needed to be married in order to feel like a woman (actually in order to feel like a person). If she were to be a "separate" person she would feel like nobody, like nothing, and she had a dread of loneliness. Sonia tells me she has one face for the world and another face for herself and for me. With herself she is depressed, desperate, nothing, nobody. With me she cries and cries and cries. She expects me to help her with her depression. If I do not, she will have to commit suicide.

Gretchen S reports having similar feelings of nothingness. Gretchen is 35 years of age, and Sonia is now 70. In a session with me in the fall of 1980

Gretchen reported the following:

> She must rid herself of her obsession of imagining that there is something between herself and a man when in fact it is “all in her head." She suffers the “tortures of the damned," imagining that she sees the man with other women, that she has done something that drives him away from her, that he will perhaps not look at her “as if she is a woman, as if she were worth something.” *[She talks of a feeling similar to Sonia’s.]* She must have that image otherwise she is nothing. She remembers a scene with her mother when she was 20 years old when Johnny *[the man to whom she is now married]* wanted her to go to California with him where he had a job. She knew she should get away from her mother, from her family, but she felt that she did not have the strength to do so. However, she forced herself to get ready to go. She was at home in the city, and her family had gone to their cottage in the country for the weekend. It was Sunday, and she was ready to leave. Her family returned, and she told her mother of her decision. Her mother said: “If you go, I will move to Florida and I will never return.” She could not leave after her mother said that. She could not conceive of life without her mother. Without her she would be “nothing.”

Shortly after that she said the same of Will, the latest man. who she imagined was in love with her. She utilizes this image to keep herself as a person; otherwise she is nothing. All she wants from Will is to recognize that she exists. She does not exist unless he will tell her that he cares for her. values her, thinks she has some sexual charm. She realizes she must have a woman in the picture, a competitor, someone who is preferred over her. She thinks this is a triangle—herself, her father, and her mother. Her mother is preferred; she has sexual charm. Gretchen thinks that the thing that gives her mother preference is that her mother has *feelings.* Gretchen is “dead”—she

has no feelings (depression, depersonalization).

> She describes her "state" as a person who is numb, no life, no spunk, no feelings except as she can respond to a great figure like Will; this gives her life, but her life in this way is torture. She has had this problem for many years. She experiences this pattern *[idealizing a male figure, imagining he is in love with her, and then watching every move he makes and thinking that his behavior refers to her].* She cannot live this way. If she cannot resolve this problem, she will have to commit suicide. She thinks of her marriage, but it means nothing to her. *[She has been married for several years to a man who cannot support her.]* Johnny *[her husband]* "has all he can do to keep his own body and soul together." He has nothing to give her. She is the one who has to give to him. If her mother did not give her money, she could not exist. She can work, but when she gets a job, she always begins to focus on some man at work. In the end she is so tortured that she has to leave or she is asked to leave because she is so disturbed. She cannot live this way.

Both Sonia and Gretchen have feelings of being nothing, feelings of being detached, lifeless. When they put on a face, they are merely play acting —it is not real. I tell them that this is real, but so is the other feeling. They are split—Dr. Jeykll and Mr. Hyde. Their feelings of being nothing are what some people refer to as "depersonalization." Without another person who gives them cues so they can live and feel, they are nothing. Others think of this as "separation anxiety" and account for it as if the individual could not separate from the mother. (What Margaret Mahler calls the symbiotic stage; they have no individuation.) It is a denial of their own value and existence and a blotting out of feeling. Probing will reveal that these people have had such feelings since childhood. I have learned that these masochistic fantasies, tortured

feelings, have been present in the life of these patients since the age of 4 or 5 and are really various repetitions in a variety of forms of the "beating fantasy." In adulthood these fantasies defend an identification with the most detached and most hostile parent, often the father for girls and the mother for boys. The mothers are hysterical and need the children for protection; they are the foils for the parents' projections.

I have learned also that these patterns are associated with *perverse fantasies.* Gretchen reported having a telephone experience that she insisted was a call by Will but appeared to me to be the call of a pervert, which so many people experience in a big city like New York.

> "He called me. You see, he wanted to be in touch with me—but he said nothing. When I said. Hello, he said nothing but I could hear background noises that I recognized. He was playing games." Then she describes one day when Will really talked. "He called and I answered. He said, "Do you love me? " I said, "Yes." He said, "Do you need me? " I said, "Yes." She then spoke of her most recent suicidal attempt when she felt she could not stand the tension of needing him and not having him.[18] She told me that her brother had come to be with her when she made the suicidal attempt *[swallowing pills—50 Valium tablets].* He had told her that some men do play games. They are teasers. He said they are "head fuckers." I had not heard this term. She said it was in popular use in the 1960s with the younger generation. "Head fucking" was sexual fantasy and secret communication among men and women but never coming across physically. Will was a man who played games—a "head fucker." She thought of her father *[but did not elaborate. Her father was, so far as I can make out, a peculiar fellow].* She describes him as detached and zombielike. She tells of sitting on his lap even when she was in her twenties and of her mother saying she is too old for that. The father liked it, she said.

She had told me earlier that her father could not verbalize well. She often became irritated with him. She could not imagine that her father and mother could have sex and enjoy it because of the way her father acted, but her mother said they had a good sex life. Gretchen herself was always sexually "mixed up." She was very disturbed in adolescence—wore old clothes, unfeminine clothes. Her mother shopped for her and bought her unfeminine clothes. When she would shop for herself and get feminine clothes, her mother would protest and say the clothes were too frivolous. When her father bought her something, it was usually a boy's shirt. She related how she used to sit on her father's lap with her boy's clothes. She was always overweight—as much as fifty pounds at times. She would lose weight but then would gain it all back. Gretchen is a very tall girl (six feet), and when she was overweight, she did look awkward and huge. During the past year, she had lost over seventy-five pounds.

> She did it for Will. She wanted him to see her as feminine. She had such loving feelings for Will. She never experienced such loving feelings. She could never have lost all that weight if she had not found the strength in her love for Will, it kept her alive. She needed him just to survive.

I mentioned that she has used these words about her mother, and I talked about transference. She was confused, stating, "I thought of my father because Will is a man, not my mother." I told her that both kinds of transference could be operating. I talked of the secret communications between herself and Will and his shying away from real sexual contact. She

replied, “But I sat on my father’s lap.” (Gretchen had, many years before, told me of some sexual experiences she had with a married man whom she idealized, who wanted only to have her expose her bare back and backsides to him while he gazed at her. He was an artist. She gave me the impression that he used her as a masturbatory object and she let herself be used because she “wanted to be close to a man.”)

Gretchen was very interested in transference and said that this is probably the key to her problem. She spoke of the problem in realistic terms whereas minutes before she had been speaking as if her fantasies were real and actual interpersonal experiences. It is my thought that she did have “secret communications” with her father and that there was a “nonverbal sexual equivalent going on between them.” She would say that her father could be in a room with her for hours and never speak. It is a fact that her mother did squelch her expressions of femininity and that in adolescence she dressed like a boy rather than like a girl. She has always been frigid sexually and in fact has had very little real sexual experience even in her marriage. She thinks very little of her marriage. She needs somebody in the house, somebody to be there. It is also true that her husband has never supported himself until comparatively recently, and he has never supported her. They have often talked of separation but still remain married. He has been in therapy for years and recently has told her he might like to have a divorce. She has criticized him and has been hostile to him for years, saying they

should divorce. When he recently thought it might be a good idea, she, however, began to be afraid to be alone.

My concept that sadistic feelings lie behind the masochistic fantasies comes from the many dreams of my patients that have revealed these dynamics, particularly when associations to the dreams are obtained. When Gretchen evinced interest in transference feelings, she asked how one goes about resolving a problem like hers by way of understanding the transference. I told her that one talks about one's feelings toward people, including the therapist, whatever those feelings may be and one discusses dreams and fantasies. I then asked if she has had dreams recently. She said that she had, but they did not seem relevant to what we were discussing. I asked her to tell me the dreams in any case. She hesitated but finally complied with my wish even though she obviously thought it a silly exercise. She reported that she dreamed of her current obsessive object, John, a man she met in an exercise gym who has said that he likes her. He works at the gym on Saturdays, a second job, in order to earn extra money. (She has decided that he likes her and she loves him and often she would go to sit with him to talk with him. On one occasion, she waited for him while he had business for one hour away from his desk. A woman who works at the place wondered what she wanted, "Why are you sitting here?" This experience embarrassed her somewhat, and she stopped lingering at his desk. She does not go to the gym on Saturdays in an attempt to stop her impulse to be with him [her acting out]

even though she wants to. She does call him frequently on the telephone, and he answers. She realizes he has no time to see her, but she is sure he likes her and that is enough for her at present.) In response to my prompting, Gretchen reported the following dream:

> John was dressed in a uniform, the same kind of a uniform that she saw in a scene in M-A-S-H where one of the men who was "very good looking," and whom she could love, was being accused unjustly by some other person and was to be brought before a magistrate. They were all dressed up in their fine uniforms rather than the "shit clothes" that they ordinarily wear. [She sees no relation to our subject of transference.! I said, "An innocent person is being accused and his life is in danger." She said, "I am endangering John's life." Then she lapsed into obsessive talk to drown out what she had said.

I have the impression that she could mean that when she "loves" a person it is really that she bedevils them. She pesters them and gains some hostile pleasure. Such patients resist deepening of the transference by such behavior as deflecting the conversation to unimportant details of current events, or by humor, or by utilizing the trappings of the external effects of analysis in a defensive way. There are innumerable ways that the patient can do this: the patients conceal information from the therapist, or lie about situations, or present the material in such a dissociated or distorted way that it is difficult to follow. They use denial and many other distractions from the analytic transference. Of course, all of these maneuvers are defenses. The therapist at the third phase of treatment must learn to confront the patient with certain transferential material. For example, I spoke with Sonia about

her reactions to me and to Dr. Wolberg. Her first direct transference to me was similar to what she said about Dr. Wolberg—that we were cold and unresponsive. This is a transference reaction. Whom do we represent? It sounds to me like her father. I know however that she is talking about herself, the ways in which she is like her father, particularly his sadistic side. But I wait to interpret this until later. I will at another time say that her father was always expecting death or holding his death over others. When Sonia talks incessantly of committing suicide, she is acting like her father did when he was threatening the family with his death. This is Sonia's "identification with the aggressor." But she has other manifestations of this identification as well, for example, her rigid standards of conduct. Resistance of this kind has been called a negative therapeutic reaction. We are told by "orthodox" theorists that negative therapeutic reactions stemming from unconscious guilt and excessive superego pressures are prognostically more favorable in contrast to negative therapeutic reactions derived from primitive preoedipal envy and negative therapeutic reactions corresponding to a "psychotic identification" (in Jacobson's terms) with a primary sadistic object representation. I see these as reactions that refer to relations with parents in both oedipal and preoedipal periods, certainly corresponding to what Jacobson (1954) has called "identification with a primary sadistic object representation." In order for the identification to persist, this pattern with the parent must last over a long period of time.

In the last part of the third phase of treatment the patient stresses his feelings of regret that he could not have had a better relationship with his parents. He is still angry about this, but he is able to talk about his anger more directly and pinpoint his past with his parents as the source of his depressive attitude. He can now speak of his parents' patterns and those of his own that are like the parents. Certain defenses still remain. The patient may say, for example: "You see, I didn't know that I was capable, had brains, could operate as well as the next person. I know now that I can do anything I want! I can lead, I can plan, I can think"—this can be presented in the form of a manic like outburst. "I'm not going to take any more crap from anybody—not anybody. You *[the therapist]* knew I had these skills, but I didn't *know."* The speaker of these words did not mean that he didn't *know.* He was a man with a Ph.D. in psychology. What he meant is that his masochism was such that he would not allow himself to accept what he *knows.* The patient knows that he can think, that he can perform, *but now he accepts the fact emotionally speaking.* He accepts himself without conjuring up the punitive superego, the identification with the aggressors, the internalized pathological object relations and the guilt that has been interfering with his behavior. He might say, "I felt it but I didn't know it." The therapist says, "I think you denied it." The patient now begins to act at times in an obnoxious way. He says he will not take any derogatory or sarcastic remarks without retaliating, and this occasionally becomes ridiculous. He feels he must retaliate even when the other person is

obviously being neurotic. Such a point is sometimes unbearable for the person with whom the patient may be living. It is at such a point that the person who has had no training in manners or decorum who has not been taught the basic amenities of life can be truly inept and obnoxious at times. It is at this point that the patient may have difficulty in his relations with peers. If the patient has been in a group-therapy situation, he often wishes to leave the group since he cannot tolerate the anxiety of his acting out with authorities or peers. He is learning that the group is not like his family. The group, the individual, and the society are the triad of connected elements. His family supported his neurotic ways, the group and the therapist do not.

Although the patient had difficulties with authorities and with peers previously, his behavior is now different: he is assertive where before he was hostile and withdrawn, but his assertiveness is fused with hostility and with neurotic reactions in response to the neurotic behavior of others. He understands the neurotic behavior of others, but he still reacts punitively.

The therapist realizes that a therapy group is an important vehicle for the patient. His suggestion for the patient to go to a group must be much more carefully made at this time, however, and the suggestion more precisely explained, for the peer experience will be much more complicated than it would have been if the patient were just beginning treatment. Now the patient will be in the position of having to make an unneurotic adjustment to

peers while initially he acted in a defensive way and was not required to give up his defenses, only notice them and see where they were most forcefully used. The task is different now. Therefore, he cannot be placed in a group of people who are novices and who are just beginning treatment. His fears and resistances to working through his anxieties are different from what they were in the initial stages of treatment. He can react both punitively and masochistically.

Group Therapy

When and how to introduce the borderline patient to a group is a matter for some discussion. There seem to be no general rules that apply to all patients. Some borderlines feel the need of a group at the beginning; others do not and will not be convinced that a group is useful in the early stage of treatment. Some will enter in the middle stage, while others will do so only when they feel they are in the last stages. Some borderlines have difficulty transferring to open relationships, and others are very familiar with peers but with neurotic peers whose goals are acting out. When such patients find that the therapy group does not encourage acting out, they want to leave. Some borderlines will reduce their acting out, but they must cling to some shred of an acting-out pattern, one that is less harmful than the major pattern has been.

At some point, however, the patient should join a group that will help in his working through in the third and fourth stages of treatment, for it is at this time that he will complete his analysis concerning authorities and peers. He will learn some cooperative ways of working with peers and with authority figures. He will learn that an individual is a member of a group by virtue of his activities in the group.

The individual represents genetic, biological, neurophysiological, and social action. The individual is a member of the group through the communication roles he performs to give and take information. Each group is a new experience, even if some members have been in groups before, for as Moreno (1934) pointed out many years ago. each group is different from every other group due to the subsystems, i.e., the various combinations of communication chains that arise. The individual is connected to the group by his *role* and his role as well as the roles of the other members change as they are either cooperative or defensive as the case may be. Dealing with the dynamics of groups means that one must have, in addition to psychoanalytic concepts, some group concepts as well for psychoanalytic concepts cannot explain the total group process. The group is not an individual. The group is a group of individuals, but the group has no “ego,” no “superego.” no “id" nor does the group translate into “father,” “mother.” or “family.” It is true that in transference individual members may feel that the group is a family. The group is supportive.

The borderline patient needs a group therapeutic experience. Sometimes the patient attends several kinds of groups before he can join a psychoanalytically oriented group, e.g., a discussion group, a social group, a work group. Active work, learning work roles, and accomplishing work tasks are most important in the therapeutic goals of borderline patients.

For the borderline patient group therapy is a necessity, but it can be a process that may be interrupted several times. It is the patients who have a very social facade and who hate being alone that sometimes go into group therapy at the start of treatment. They are often afraid of a one-to-one situation because of the intense rage that such a relationship evokes. They are able to focus transferences on several group members (Lipschutz, 1957) and feel safer in the group. Later these same patients may become afraid of the group, but they are not in a position to analyze this fear so they leave and cling to the one-to-one situation. Usually in the one-to-one situation—soon after they have seen the sadomasochistic patterns that bind them to the "other"—these patients will then begin to work through the core of their problem. That problem is to recognize the strength of their aggression and the core of defense (detachment, denial, projection, displacement, etc.) that holds them and keeps them from having decent relations with other people. As they work through this problem and its implications, they then begin to think of joining a group again. The kinds of sessions that can lead to the patient's planning to join a group a second time are illustrated in the

following with Gretchen. After she heard me talk about her strong feelings for Will (the reader will recall that Will is one of the men whom she focused on at work and whom she imagined as her lover and in secret communication with her), her feelings were aroused by the fantasy of the man. She spent several sessions during which she would alternate between talking as if the fantasy were real life and accepting it as fantasy. She did feel good about having sexual feelings and knowing that she could have them, and I agreed with her that she can have sexual feelings. In the past she had misgivings about ever having real feelings. In session she spoke of her need to have another woman in competition and related this to the triangle father-mother-herself. She stated that she would try to get Will away from his wife. That would give her satisfaction. It did not matter if he never had sex with her; she would be satisfied with just his voice indicating that he considered her worthwhile.

In several sessions she spoke about her despair over her body: she was hopeless; her body was grotesque; if a man saw her body, or if I did, it would be obvious to any observer that she does not have a good body. "I am a piece of shit! " "No man would even accept me." Gretchen is married but unhappily. Gretchen is six feet tall, thirty-five years old. She has been married for seven years but has "been with" this man for fifteen years. She begins to describe their relationship:

> Johnny is short, about five feet, he is becoming fat. She is disgusted when she looks at him. They have clung together in neurosis *[this is true].*

He is a baby. His family was disgusting. He was brought up like a pig. He always acts helpless, and she has had to play the role of a mother who is bringing up a child. She describes how her husband fails, fumbles, gets fired, says he can't learn. She is always tending him. She teaches him. He reports to her what he had done that is "bad," that makes him fail. She goes over each episode with him telling him what he should have done. She has to watch him like a hawk; otherwise he'll do something that will put them both in jeopardy. One time he told her he was late for work because he slept on the subway and went past his station. She screamed at him and said he doesn't care. She then thought of their house keys in his pocket. Anyone could have taken them and broken into the house. She recounts how she and her mother thought he should have a chance and they financed him in business. He failed, but they kept the shop because every so often he could sell something in his spare time. *[I have heard all this before, but I do not stop her.]*

Pt. He is like a baby.

Th. No. He is a man who is always failing and putting his foot in it.

Pt. Maybe he does it to hurt me.

Th. To bedevil you.

Pt. He is hostile.

Th. He acts toward you as if you were a keeper—or a harsh mother rather than a wife.
[She has this kind of relationship with her mother.]

Pt. But you know that I am hostile to him.

Th. Yes, I know.
[She then describes how she rejects him, criticizes him all the time, beats at him.]

Pt. Lately I have felt that I could really kill him. He makes me so mad. I tell him that I'm tired of being his mother. I want a different relationship. Then he'll do something that is so frustrating that I can't stand it and I go berserk. I scream and yell and

curse him.

Th. You go hysterical?

Pt. Yes, I go off in a hysterical attack—a regular mania.

Th. You seem to use each other as transference figures. He is not a husband to you but a frustrating child, and you are not a wife to him but a hostile, complaining, castrating mother. You have what we call an interlocking defensive relationship.

Pt. Exactly. *[But then she says]* I want to sift out what's my problem and what's

his. I know that I am much more hostile to him than he is to me.

Th. He is more sneaky about his hostility. You are more open and attacking.

Pt. Yes, yes.

She then begins to talk about her problem. She says that she senses that she drives people and him away from her. When he is nice, she cannot stand it, and she always manages to spoil the relationship. She thinks she did this with Will and with many men. She is left with only a fantasy. But with Henry it may be different.

Pt. Do you see? I need it *[the fantasy].*

Th. Yes, I see you need it now, but you don't need it forever. You are afraid of men. You want a man who will love you and satisfy you, but you are afraid. You drive them away. I think it is because of the relationship you had with your father.

She has told me many times about her relationship with her father, but this is the first time I have confronted her with the relationship. I do so now

because of the way she is presenting the repetition story. She is much less defensive than she has been previously. Her father was detached, hard to reach, and he used to “linger in her presence.” She repeats what she told me about her father, two episodes:

> One day father was in the kitchen reading. He came in and did not speak “but just stood there.” She spoke to him, but he did not speak. She then began to scream at him. “What do you want? What are you standing there looking at me for? Go away." We discuss this problem. She was always trying to get her father to notice her. to love her. to recognize her. She then tells again how she sat on his lap and hugged him even when she was 27 years old.
>
> She then says that she is afraid of men. She was deathly afraid of Will, and she is afraid of Henry. She was madly in love with Will, but she is angry at Henry for he does not respond. He could pick up the phone and call her. But he never does. She always has to call him.

Th. You felt you had to make the first move with your father?

Pt. Yes, I always had to make the advances. I think he wanted to love me, but maybe he was afraid of mother.

Th. I think he had emotional problems that did not allow him to think of you as a girl, as an attractive daughter.

[After what to many therapists might seem extraneous talk, she said:]

Pt. I think I must begin to talk about my problem. I am afraid of men. and I treat my husband rotten. I drive him away from me even when he tries to be nice.

Th. This seems to be true.

Pt. Your group told me that I was afraid of men—but at the time [*four years previously].* I

didn’t know what they were talking about. It meant nothing to me.

Th. You know now what they were talking about?

Pt. Yes...but I don’t know how to overcome this problem. How can I overcome it? If I don’t get over this—if I can’t remove this block, then I might as well give up and take more pills. I can’t go through another episode like I did with Will—I just can’t take it....How do I get over this hardness, this block, this resistance, and this pattern of turning men away?

Th. You are beginning the process right now—by recognizing the problem. It is your need to express your hostility that prevents you from getting close to a man. Of course, you never would let yourself realize how angry you were at your parents —your father.

Pt. No, I never felt angry at daddy.

Th. But, you can see that you must have felt angry and very, very frustrated by him. I had someone also tell me just the other day almost the same thing that you are telling me, and I told her about Harlow’s monkeys. Do you know about Harlow's monkeys?

Pt. No.

Th. This woman *[the reference is to Sonia who is 70 years old but talks about her father the same way as Gretchen does]* told me of an episode that keeps coming to her when she was 6 years old. She was in the washroom when two older girls came in and they congratulated her on something good she had done at the school. Instead of thanking them for the compliment, she turned on them and spat at them. I told her about Harlow’s monkeys. Some baby monkeys were deprived of the love they needed from a parent, and when they grew up, they were hostile to their children and to others who came near them. *[I elaborated on the situation and concluded by saying]* Some mothers were so angry that they killed their children. A few children tried and tried to make the parent get close, and a few finally succeeded, and the mothers became loving.

[The session was over. As Gretchen walked out the door, she saw a group waiting to come in

for a session.]

Th. Well, maybe you'll join a group again after you work through this problem, maybe in three months.

Pt. I was thinking about that.

Th. I think it's a good idea.

There are many other kinds of situations that indicate to the therapist when the patient has a readiness for group and peer relationships are more important. Gretchen had left the group before when she felt that her anger had risen to a dangerous extent, but she had not recognized this problem at the time. She now added as she left, "Yes, I think I would not be so hostile in the group, and I'd get more out of it now." The patient must express a readiness or a need to enter a group before the patient can actually become a member.

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Notes

18 She was seeing another therapist at the time, a man, but was disillusioned with him and had sought me out to renew our relationship. I suggested that I could see her until she could apply at the clinic, and if she wanted to see me when I was in town, even if she were seeing someone else, she could call me.