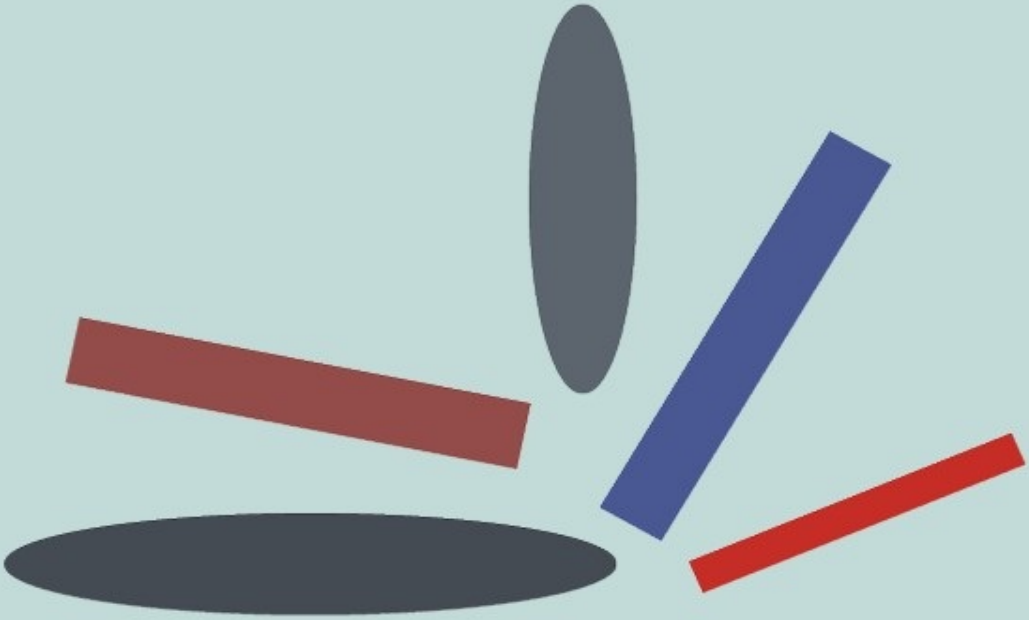
THEORETICAL ORIENTATION



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Theoretical Orientation

Psychotherapy has been under attack on many fronts. Aside from Szasz, who feels that mental illness is in the eye of the beholder, and E. Fuller Torrey, who believes that the services of psychiatrists are expendable except for some brain diseases such as schizophrenia, which eventually can be cured or controlled by a handful of drugs that will be administered by general practitioners, there are many professionals who challenge psychotherapists to prove the effectiveness of their craft. In the face of this, it is astonishing that so many different forms of treatment flourish in the field. Recognizing the dilemmas that present-day psychotherapy poses, the cover story on psychiatry of *Time* magazine, April 2, 1979, stated, humorously, in the first sentence: "Each day millions of Americans talk, scream, confront, jump, paint, dance, strip, tickle, and grope their way toward emotional fulfillment." The outcome studies on psychotherapy appear to me to reveal that lack of training on the part of most therapists is a cause for many failures.

It is obvious that millions of Americans need psychotherapy and are seeking ways to relieve their anxieties and their emotional problems. Because of the many contradictions confronting psychotherapy, substitute

alternatives are constantly being promoted—and the borderline is very prone to welcome these. Prominent among these are mind-altering drugs, such as alcohol, marijuana and the "hard stuff," all of which are used to deaden tension, take the individual "out of it," and give him surcease from his worries.

The borderline is not to be blamed entirely for his escape attempts, for one of the reasons that psychotherapy and psychiatry has been so "bad mouthed" is that within the so-called "helping professions" themselves there are relatively few individuals who have taken the trouble to receive the kind of training that is required to work successfully with individual emotional problems. The therapist who wishes to use short cuts is not anxious to undergo training that requires at least four years of study under supervision. Psychotherapy means *therapy of the psyche,* and this involves an understanding of the manifestations of the psyche from which we obtain the data with which to work—dreams, fantasies, thoughts, fears, conflicts, etc. It takes considerable time to learn intricacies of the psychotherapeutic method. Even if there were enough properly trained people, the borderline would undoubtedly seek short cuts, for he has the habit of seeming to seek help, when in fact he is loath to undergo the necessary travail for true corrective therapy. He has been conditioned in a sadomasochistic mode of life that he stubbornly holds to even as he seeks help.

Many borderlines share with many physicians the hope that good drugs

may be found to “cure,” or “alleviate most emotional disorders.” The discovery that there are many types of neurotransmitters, i.e., chemicals that provide the communication in the human neurophysiological system that help to establish certain behavior patterns, has heightened this hope. The elongated fingerlike cells in the brain and neurophysiological apparatus are connected by the messages they receive across the synapses through the release of the chemical neurotransmitters. Jumping across the synapses, the chemicals seek only those sites or receptors on the nerves that are specially designed for this task. Experimenters have speculated that when the body produces too many or too few of such chemicals, behavioral problems ensue. Depression, for example, may be associated with altered activity of neurotransmitters like monoamines (serotonin, adrenalin, and dopamine), while schizophrenia is characterized by dopamine defects. The borderline patient is considered by most drug-treatment-oriented therapists to be a form of schizophrenia, although this is still a moot point. As we have mentioned, experimental data puts the borderline in the 8 to 35 percent bracket with respect to constitutional factors. Since some neurophysiologists believe that drugs alone will change neurotic to normal behavior; they see no reason for training in psychotherapy.

It is evident, however, that the environment has something to do with body chemicals and thus with the composition of neurotransmitters. The intake of foods, as well as other types of events, i.e., *pleasant* and *unpleasant*

interpersonal experiences, have an effect on the neurophysiological pathways to the brain. Today the pleasure-pain centers and their pathways are the focus of much research. Freud put a great emphasis on the pleasure-pain mechanisms in his theory of psychoanalysis. The pleasure-pain principle is an important factor in the development of the borderline personality. It is the means through which the environment has an impact upon individual development as opposed to what Freud called the "innate schedule" or the instincts that he presumed made themselves felt at stated periods. The instincts pressed for discharge regardless of the environment.

It is, of course, in the family that the habits, customs, foods, manners, and behaviors of individuals have a direct relation to brain activity and to the kinds of neurophysiological pathways that are established leading to individual adjustment. Whether external pressures and events have a relation to the manner in which the chemicals increase or decrease or whether less or more of a given chemical is constitutionally determined is not known at this point. It is obvious that the individual, while he may be composed of innumerable systems, genetically determined, is himself an open system dependent upon the varying environmental forces that bombard him from all sides. The interactions between the individual and his environment contain variables of which we still have no knowledge.

In this chapter I shall try to summarize my ideas regarding the

dynamics of the borderline condition in the context of the theory that environment plays a decisive role in the etiology of the neuroses and the psychoses. In doing so, I shall repeat what I believe are the important dynamic themes as they appear in different forms in order to accent their importance. I shall try to explain what I think is important in the treatment regime so that the patient can modify his behavior sufficiently to relieve his tension and resolve his main conflict. This, in my opinion, revolves around his having acquired identifications with parental figures that are detrimental to self-preservative impulses. The latter are what we should think of as determined by the genetic schedule and therefore the "id." But the id, I believe, should be thought of as the *genetically determined survival equipment* rather than as some mysterious chaotic, unorganized mental miasma. The id contains the wherewithal for ego organization; in fact, the ego, as currently defined, begins to function (as Fairbairn suggested) at birth since the self-preservation instincts have prepared the way for the survival of the species.

In the first section of this discussion of theory, I shall sketch some of my ideas in broad outline regarding identification, the relation of identification to dreams and fantasies, the attempts of psychoanalysis to depict interpersonal relations intrapsychically, the transitions in Freud's thinking with respect to theory, and the turning to a developmental scheme away from the influence of the environment with the evolvement of the instinct theory, which looms so importantly in the minds of most theorists today with regard to the

borderline patient. In the minds of many theorists, ways of looking at data concerning the borderline are grouped around the concept of narcissism, the early aspects of the developmental theory such as “oral” and “anal” aggression, and the “sadomasochistic instincts” that are attached to these early phases. Fixation accounts for much of the behavior of borderline patients according to most current theories. My ideas are different, and I have tried to explain some of the differences, recognizing that on the clinical level we all see the same manifestations. In order to clarify some of the ideas concerning fixation, sadomasochism, identification, I have found it necessary to go into some of the historical developments in psychoanalytic theory. We must use sociological or interpersonal theory to explain the interpersonal dynamics that create the borderline condition. We must also use some of Freud’s ideas, particularly some of his early concepts of defense and his thoughts about identification and internal representations of experience. In treatment the interpretations of therapists revolve a great deal around their theories; yet in our actual practice many of us do the same thing *regardless* of our theories.

In psychotherapy we should be concerned with the family conflicts and the immediate environment where the individual resides. We are interested thus in the intimate human group or groups to which the person belongs and the effect that these social systems have had on the emotional life of the child as reflected in his dreams, fantasies, and symptoms. In other words, we are

interested in the way his experiences have influenced his thinking and physical reactions. It is in the dreams, fantasies, and symptoms that we find the ways in which the individual has survived by developing defenses against anxiety socially derived. The defenses hopefully counteract the anxieties that are evoked as traumatic experiences (cumulative traumas) become *dangers.* It is also in the dreams and fantasies that we learn about the conflicts that the individual has developed in relations with family members; we learn about the individual's wishes, angers, and fears.

There is little doubt that a stress-illness factor in the human body prevails *(Science News,* 1977). It is apparent also that various brain-body links are mediated by a person's endocrine and autonomic nervous systems. The conclusion of many is that "it may be that the most important factors in the stress-illness link are the chronic, daily hassles rather than major life events" *(Science News,* 1977). This is certainly true. The daily necessity to cope with work and family situations is the main problem for most individuals. An inopportune family environment results in neurotic development and thus, over time, handicaps the individual in his ability to cope with the travail of everyday life. The stresses and the defenses against the stresses take so much energy that the individual has no strength to resolve his problems in an adequate way. His vicissitudes then cause conditions that lead to more stress. Research, for example, reveals that people who are married have lower death rates than those who are single, widowed, or divorced. Persons undergoing

bereavement, separation, and other situations involving loss of a loved one or "dashed hopes of being cared for" are identified as high-risk gastrointestinal patients. Members of groups experiencing social and cultural mobility have higher rates of coronary heart disease, lung cancer, difficulties of pregnancy, sarcoidosis, depression, and other neurotic symptoms than members of more stable groups. Behavior and cardiovascular processes are intimately linked. Hypertension and job loss, economic deprivation, and crowding are linked. Men who work in supervisory roles get ulcers at a significantly greater rate than those in other work roles.

The borderline patient is a tense person. He has been "programmed" in a conflict-laden environment, and his relationship with his environment is thus full of everyday "hassles." It is the nature of the borderline to find adjustment extremely difficult since in his family the customs or the mores (the normative behavior) are at odds with what the larger social group expects of the individual in the way of interpersonal relations (Wolberg, A., 1952). The borderline's mode of behavior is sadomasochistic, and he cannot make an adequate adjustment to authority. He resists the demands of authority; yet he has been taught in his family that he must knuckle down to authority whenever authority demands this. His fantasies, dreams, fears, anxieties tell the story of a person whose developmental years were linked with parents who were bound together in a sadomasochistic interpersonal defensive system and who utilized their children in the service of their

neurotic struggle. The child is a member of a social system (the family) that attempts to shut out some of the influences of the other social systems of which the family members must inevitably become a part. Within the family system the children are cogs in one sense (projective objects); on another level they are expected to conceal the dehumanizing aspects of the family system from the members of the school system and the broader social systems such as clubs, leisure time activities, sports groups, religious affiliations, work groups, and such.

In the family we often find that in addition to being sadomasochistic the parents of borderlines have a depressive attitude. Myrna Weissman (1976) found that depressed women lack energy and are apathetic and are not interested in their children. We see this condition often in mothers of children who later become borderline. The depressed woman, says Weissman, cannot communicate with her children; she exhibits hostility toward them and loses her feeling of affection for them. Borderline patients usually have mild chronic depression related to feelings of having been rejected and abused by their parents. They feel uncared for. They are suffering from what Freud called the feeling of having "lost their objects." While they *have* "lost their objects" in one way, i.e., they have felt the brunt of rejection and abuse, on another level they have retained their original objects through their identifications, which are the ways in which they are like the neurotic aspects of the parents. They are separate, but they are also tied by their

identifications, and they are filled with self-disgust, anger, rage, and depression. It has been my observation that the depression of borderline patients is not a severe kind of depression, but the parents of borderlines when they are depressed, usually are more than slightly depressed and manifest hostility rather than extreme withdrawal as in the severely depressed person.

The treatment of a neurosis and even a psychosis is best advanced, it seems to me, under the aegis of a dynamic psychoanalytically oriented theory. But traditional theories it must be recognized have some defects that will need correction. In the field of psychoanalysis little was done for the borderline patient until comparatively recently due to Freud's idea that these cases were untreatable. One of the great handicaps has also been the rigidity of some psychoanalysts in their belief that if one is not seeing the patient five times a week and if the patient is not on the couch, then one is not doing psychoanalysis. Dynamically oriented psychotherapy, which seems to be the treatment of choice for borderline patients, is not psychoanalysis according to the rigid definition. Analysts who insist on being purists refuse to treat borderline patients, for when they do so, they believe they are not being true to their standards. Common misconceptions are that if the patient sits up, it is not psychoanalysis; and if discussions and activity on the part of the therapist take place, this is not psychoanalysis; if the patient does not have a transference neurosis, the procedure is not psychoanalysis, and so forth and

so forth. The criticism is leveled at the psychoanalyst by many nonanalysts that psychoanalysis is a "cold" procedure, a one-sided discussion, with the analyst limited to saying "Oh hmm!" All of these criticisms are obviously naive, but many psychoanalysts *do* have a rigid view of psychoanalytic procedure so in fact they are not able to treat borderline patients.

Projective Identification—A Main Defense in Borderline Personality

Throughout this volume it has been stressed that one of the major defenses of the borderline patient (actually, this is a system of defenses) is *projective identification.* We must reinterpret this concept, however, in a way that differs considerably from the ideas of Melanie Klein who introduced the term in the 1930s and from those who more recently utilized Klein's concept of the mechanism in infancy as a defense against "oral" aggression. While I use the concept of projective identification as a defense, I consider that the infant who will become the future borderline patient is born with the same psychological and neurophysiological equipment as the individual who will have a more "normal" development. Klein's concepts of oral aggression, of the schizoid and depressive positions in infancy, must give way to more rational explanations. *The experience with the parents is what determines the way in which the defenses will be organized.* Neuroses and psychoses are systems of defense. The borderline has a particular kind of ego defensive system.

We have seen that projective identification can be interpreted to be a defense unrelated to developmental phenomena, a defense that is organized gradually over time and is solidified later than in infancy through relations with parental figures. The developmental theories of Freud, Klein, or Mahler as these apply to the dynamics of the borderline deal with the so-called preoedipal phase of development and are inadequate to explain development as revealed in current infant studies. The new information regarding infant development will change our ideas about infant life, emotional and mental. Therefore, they will require that orthodox psychoanalytic theory, particularly as related to the first three years of life, modify its preoedipal concepts. Such concepts as "developmental arrest," "fixation," "innate oral aggression," "sadomasochistic instincts" that appear in the "oral" and "anal" stages connected with biting, breathing, "taking in," or "expelling" are useless in the understanding of borderline conditions. Current ideas regarding an objectless stage in infancy and concepts of narcissism will have to be discarded.

To reiterate once more, projective identification is a defense developed over time in view of the particular experiences the child has from birth onward with parental figures, both father and mother. The aggression that is an aspect of projective identification is a primary symptom in borderline conditions, but it is evoked by repetitive traumatic experiences with parents, who excessively control and inhibit the child's behavior. Later on, aggression is tinged with ideas of hate and revenge, which provide the basis for the

necessity for developing the projective identification defense. The frustration-aggression hypothesis explains the dynamics and the foundation of ideas concerning aggression. In general, the concept of "ego defect" should be replaced by a new concept of "defense," one that posits that the borderline individual denies the true nature of the reality situation in the parental home. The situation is too anxiety provoking for the child to accept as is, and he relieves his anxieties through symptoms, defenses, and other means, often through the use of alcohol and various drugs. A sadomasochistic role is assigned to a child by his parents, who have an interlocking defensive interpersonal relationship and who use the child as a transferential object in the service of their own requirements. The sadomasochistic role is based on the parents' urgencies to employ the child as a projective object in their own defense, and their punitive and controlling modes require the child to inhibit certain of his "normal" impulses or "needs." These normal needs find expression periodically based on the fact that they are instinctually or genetically organized and form part of the self-preservation aspects of the child's behavior. The ensuing neurotic and psychotic processes evoked in the child are defenses against a harsh reality with which the individual tries to cope, and the crucial defense mechanism is identification with the parents who are aggressors in that they use inflexible controlling mechanisms and punitive measures to keep the child in line with their neurotic needs. Sadomasochism is a *learned* pattern in this relationship with parents. In

projective identification there is passive and masochistic behavior with sadism as its goal; the parents insist on a sadomasochistic position as a defense against their own intense aggression. The patients deny certain aspects of their autonomy and, out of rage and revenge, force others to do for them what they should do for themselves.[16]

Identification in this situation is not a form of development or ego growth but rather a sadomasochistic type of object relations, and in psychotherapy this projective identification has to be unraveled and broken up. For example, in transference the borderline may think of the therapist as a sadistic parent image (father or mother—or both), while the patient experiences himself as the frightened attacked child; then, even moments later, the roles may be reversed. The initial goal of the therapy (which may take three years) is to show the patient that in his projections, his dreams, and his fantasies he sees in others what is also in himself. This serves to explain to the patient his "internalization of the identifications" and his defenses against the implications of this internalization, which include repression and denial. In treatment the dreams connected with repression and denial make it possible to discuss the unconscious motivations, the fantasies, and the defenses of "the other" as a first step in the analysis of the patient's identification system. These goals are accomplished essentially by confrontation at appropriate times (when the patient indicates the points of least resistance). Projective identification in a woman patient was evident, for

example, in her denial of the sadistic side of her controlling mechanisms when she said that she is really "good." She would never have acted that way with her sick neurotic mother (a hostile way) if her father had not made her do so. She denied that she acted this way with her husband, although in previous sessions she had alluded to this.

Projective interpretation is a first step in outlining an interlocking defensive pattern between two people. The purpose of projective identification is to defend the patient both against his own powerful aggression (his reactive aggression) and his fear of destructive retaliation from others as a response to this aggression. As a defense, he projects his aggression onto others, while at the same time he gives direct expression of it in his interpersonal relations. The mechanism also helps the patient perpetuate the inhibitions and other defenses that help him continue his sadomasochistic bind.

In the beginning the child fights against expressing the identification but finally he succumbs due to the punishments and the encouragements he receives—the verbal and nonverbal communications that indicate the parents' wishes that he act out the identification roles.

In my 1973 book I have schematized this model, which, in fact, describes the milieu in which the oedipal situation develops (Wolberg, A.,

1973, pp. 159-161). The result for the borderline is a "confusion of sexual role" that is associated with what others have called a "lack of identity," but in reality it is a function of a latent homosexual trend. The kind of interaction in the family depicted in the oedipal model is what I have termed an *interlocking neurosis* between mother and father (1960, pp. 179-180). Later, equating neuroses and psychoses with *defensive systems,* I spoke of this parental relationship as being *an interlocking defensive system* (1973, pp. 2, 147-149). The borderline patient has a compulsion to express aggression. This obviously is not limited to borderline cases. Freud reported such a need in himself. He said he always needed "an enemy," and we saw this acted out in his relations with Breuer, Fleiss, and Adler. He needed a friend and an enemy simultaneously. His hostility toward the opposite sex is evident in his writings. Sadistic patterns showed in his scorn, his tirades against those who disagreed with him, and the like. Yet he had great compassion too. The projective orientation of the borderline patient makes projective therapeutic techniques a necessity.

Chessick has called the projective technique an "externalizing of the introject," a phrase coined by M. Coleman, referring to the patient's mental projection. In my terms "externalizing the introject" would refer to the identification role and to projecting or displacing one's own characteristics onto others, i.e., one's unwanted patterns (denial patterns) that have to do with identifications with parents, *the characteristics of which one feels*

ashamed. This is a basic mechanism in projective identification. Thus, "introject" would mean identification, and identification refers to an acting-out role related to parental insistence.

In discussing identification we should recognize that while in some instances the patient has the exact kind of behavior as that of the parent, in other ways the same patient "acts out" according to various patterns that are dissimilar to the parents but are, nevertheless, within the boundaries of the type of sadomasochistic behavior that would titillate the parents or appease them. I am aware, of course, that many theoreticians feel that the borderline has no identifications, and, developmentally speaking, he has not reached a point where these can be formed. Obviously, I disagree with this point of view. I know also that some theorists contend that the borderline's acting out has no relation to his identifications or his relations with his parents—but again I disagree. The studies of Szurek and Johnson (1952, 1954) with respect to the delinquent acting out would seem to confirm my viewpoint.

The patient must eventually see the relation between his acting out and his interlocking defensive relationship with parents, i.e., his identifications with them. The patient must see this or, rather, *admit* this (he sees it in any case and knows it on a cognitive level). That is, he must verbalize what his "observing ego" sees, and he must then talk of the necessity of ridding himself of the patterns and of dealing with his resistances to change. *It is in the*

resistances and in the attempts that are made to change the neurotic behavior that one sees the emotional difficulties that are associated with the patient's conflict.

The Families of Borderline Patients

It is possible to make several generalizations about the families of borderline cases. Borderline patients come from a family in which the parents were unable to provide a functioning social unit adequate for healthy development. Mothers are found to be very disturbed in a variety of ways and can be classified as (1) obsessive-compulsive, (2) self-oriented, competitive, and masculine, (3) paranoid, or (4) passive, schizoid. In many cases the mother is "there," but she really is not. That is, she may profess avid interest while ignoring many of the child's needs; she goes through the role of homemaker and mother, performing all the "duties" of the role yet not giving thought to herself or the child as persons; and she is preoccupied with her own fantasy world; she is withdrawn and neglectful.

Fathers of borderline patients can also be classified under four categories: (1) passive-aggressive, (2) hostile, aggressive, attacking, and controlling, (3) paranoid, and (4) mildly psychopathic, promoting antisocial behavior.

I have proposed a model of triadic relations in the family of the

borderline, based on Freud's continuum of acceptance/rejection in the severity of emotional disorders. The interaction between mother and father posits different patterns for male and female offspring. For males, the father is rejecting of the son, *pushing him toward the mother.* The mother expresses hostility toward men by pitting son against father. Yet, because the son needs the father, the son identifies with his hostile patterns, with ambivalence, guilt, and hatred. He also identifies with the mother. In the case of the female patient, the mother is seen as rejecting the daughter, *pushing her toward the father.* The father expresses hostility toward women by pitting daughter against mother. Thus the child develops identification fantasies serving as defense mechanisms against a traumatic family situation. These fantasies indicate the sadomasochistic role assigned the child by the parents when the child becomes enmeshed as a projective object in the services of the parents' defenses.

On a cognitive level, to use a current phrase, the patient must relate his fantasy to his current behavior and change his behavior, even though in the beginning anticipating change will give him anxiety. The family dynamics (interactions) are most important in understanding the origins and types of identifications that the patient must act out. The "observing ego" is the cognitive aspect of the patient's role in treatment. Here again I disagree with those colleagues who say that the borderline has no observing ego.

Jackson (1951a-c) and his associates (1964, 1965) studied the communication system in the families of schizophrenic patients, which to my way of thinking is similar in many ways to that in families of borderlines where the patient's parents make known their neurotic wishes and their needs for the patient to act out the neurotic identification role. Jackson spoke of *acting out* as being *in the nature of the dynamics of a post-hypnotic suggestion.* The parents communicate their neurotic wishes but, nevertheless, deny what they are doing and demand that the patient deny this as well. Nevertheless, through punishment and reward they see that the child acts out the identification roles. This dynamic helps the parents perpetuate their neurotic homeostasis, thus enabling them to avoid self confrontation. The masochistic trait in the patient's personality comes from the experience of being controlled and punished by the parents whenever he steps out of his identification role. He is finally conditioned to act out the role whenever one of his normal impulses that is threatening or anxiety provoking to the parent begins to express itself. He inhibits the impulse himself when his normal desire is about to influence his behavior. This conditioning is a result of the "Yes-No" attitudes of the parents, *but then he acts out after the inhibition of the normal impulse.* The patient has a reality concept of his situation even as he defends, denies, and distorts reality. The patient's rage and his *feelings of humiliation* are aroused in his relations with his parents, and gradually over time he develops the borderline condition. He has undoing mechanisms that

he applies to normal impulses and to some of his more dangerous aggressive impulses as well. These patterns are observed in the relationship with the therapist, and they constitute aspects of the transference. The patient's reality system is in operation simultaneously with his defensive system, which contains his distortions, repressions, and denials.

I have described the mothers and fathers of borderline patients elsewhere (Wolberg, A., 1952; 1968, pp. 109-111). One must point out that there are great variations in the combinations of fathers and mothers. In general, one is "sicker" or more mentally disturbed than the other. It may be the father who dominates the scene in one family, while it is the mother in another domestic milieu. There are some common conditions, however. One parent must be "protected" and appeased more than the other. In the family of my patient James Weber the father controlled the family. He is obsessive, domineering, and hostile. The mother is more passive, and she appeals to James "to be good" so that the father will not "take it out on me." The mother gives the impression of being a passive but hostile schizophrenic. In the original home of another patient, James Fuchs, the father also dominated the scene. He, however, was the more unstable of the parents and was finally hospitalized as a manic-depressive psychotic. The mother was passive and in my opinion was probably schizophrenic in view of her bizarre behavior with James (see Wolberg, A., pp. 252-2531. She was never hospitalized, for she lived in a protected atmosphere. The father was action oriented, a liar and a

cheat in business, and an acting-out person. The mother "lived through" James's acting out and must have experienced sadomasochistic pleasure from the father's antics as well. James's main fantasy was a "Tea and Sympathy" fantasy in various forms at various times. His acting out was based on identifications with both father and mother, which is the usual case in borderlines. For example, the father was teaching James to cheat and bribe his way through life while the mother was relating to him in a "Peeping Tom" way. He was acting out and endangering his existence by operating on the edge of the law (or over the edge) and he was also acting as a Peeping Tom.

Acting out is based upon the activations of the patient's identification fantasy that originated as a defense as the parents projected a role upon the child and demanded his acting out of the role. The projected role was dependent upon the sadomasochistic relationship the parents had with their parents. The identification fantasy of the borderline serves as a defense against the anxiety he (the borderline) feels in the interpersonal dilemma of being forced to identify with his parents or their substitutes ("the aggressors"). The fantasy aids in the denial of reality and gives the individual "distance" from the traumatizing objects (the parents or their substitutes) with whom he must deal daily. The patient in his relations with others projects traumatizing roles upon others as an aspect of his defense of projective identification. Harriet Hamburger's mother ruled through hysteria. She was a "Queen." When Harriet was born, the father said, "Another Queen

has been born! ” The father and mother both shared this “Queen” fantasy with regard to women. The father was afraid of women and had a suspicious nature. In dress he was somewhat of a dandy. The mother had fantasies of the father being unfaithful. The father was a “masochist in business,” letting his partners “cheat him and walk all over him.” He told Harriet to appease the mother in every way, but he had a “secret” with her, telling her of the difficulties in living with a hysterical woman. Harriet slept in the same bed with her grandmother for several years. The father would say, when Harriet wanted to “get close to him,” “Go to your mother! go to your mother! ” She resented having to stay with women, but she too finally developed the Queen fantasy with contempt for men. Harriet’s Queen fantasy is an identification fantasy.

The fantasy is not a true memory; it is stimulated by memories or experiences that were traumatic and have created conflicts that have never been adequately resolved. The conflicts provide the basis for the anxiety that motivates the patient to seek treatment. These conflicts relate to inhibitions that were demanded by the parents but that have interfered with the autonomous behavior of the patient and his normal impulses. Even though he inhibits them, they, nevertheless, seek expression.

The identification is a function of the patient’s superego organization. Originally, Freud connected what he called the “criticizing faculty of the ego”

with a dynamic he described as “the ego as altered by identification,” (Wolberg, A., 1973, p. 102). He seemed to imply, correctly I believe, that in an identification there is associated a form of aggression. Freud talked of the superego having some mysterious connection with the id that “is not yet understood.” Rickman (1926) spoke of the superego as the way that the individual had of “maintaining object relations.” The superego is a concept that can only emerge as a consequence of human relations, and at least in Freud’s writings we find that this concept was associated with “good” and “bad”—with our ideals and with our aggressions. The mysterious connection of the superego with the id was never clarified, but there was in his work a trend describing the child’s idea of the parent as “good” and as ’’bad” due, I presume, to the parents’ punishments and rewards.

Punishment and reward is a dynamic in the pleasure-pain reactions of the child. It is my thesis that the punishment-reward system is operative in the parents’ neurotic relations with the child, and this influences the superego, which has, through the process of identification, encompassed some of the neurotic fantasies of the parents. These fantasies, in turn, stimulate, in transference, hostilities, aggressions, and perverse habits. Freud’s idea that in identification the ego is remodeled is a way of saying that identification changes the ego, meaning the behavior of an individual, so that it is in some ways like that of another person—a person “loved” or “feared.” Object relations are implied in the concept of superego—i.e., the superego is a

concept that embraces the influence of particular people in the environment on the development of the patient's personality. It is in the concept of the superego and in family dynamics that we must recognize that psychoanalysis must derive from multidisciplinary concepts and be a systems theory rather than a developmental theory.

The Borderline Personality, A Gradual Acquisition

The borderline syndrome develops gradually. The problem, as I stress again, is related to the use of the child *over time* by the parents as a projective object in the face of the parents' anxieties. The identification is a life-saving mechanism, albeit a defense. The child feels rejected because of the activity of the parents in pursuing their neurotic aims. One can say that the superego is in part a self-destructive mechanism due to the parents' needs to utilize the child to maintain their neurotic homeostasis. The child has been made to believe that he must act out the identification role in order for the parents to survive. He is a cog in the balance or organization of the family. If the child attempts to break out of the neurotic role, he is made to feel guilty. His action is looked upon as aggression toward the parents. The guilt is now an aspect of his superego. The destructiveness of the parent in forcing the child to identify is a danger that the child fears, and he *idealizes the parent,* in defense, at the same time that he "gives in" or "knuckles under" at the insistence of the parent. *The child develops self-hatred for his "giving in," or his "weakness"—to*

be more precise, for his masochistic behavior. He feels rejected by the parent and is depressed as a result. As he becomes depressed, however, he develops anger toward the parent and resentment for the way that he is used. He must find ways of controlling his anger to some degree. Therefore, he develops repressive defenses, denial, hypochondriacal symptoms that represent symbolically the injuries the parent heaps upon him and are often indicative of the sexual usage the parent makes utilizing the child as projective (transferential) object. Over time the anger becomes associated with sadistic sexual feelings aroused by the parents as they invite the behavior to assuage their own guilt in the face of their use of the child on the sexual level.

There is, however, an "innate schedule" that unfolds for each individual, and I dare say that this schedule changes over time as the culture and environmental circumstances of the society change. A given individual is but a small iota in the history of the species, but each individual has an innate schedule that is the basis for his self-preservation techniques. Such phenomena as defenses that appear shortly after birth, gestures that are evident by the age of 2 months, eye contact that is present shortly after birth, smiling, cooing and other verbal utterances, communication techniques, and many other neurophysiological phenomena are evidences of these self-preservation mechanisms. There is an interesting neurophysiological phenomenon that has recently been brought to our attention by McCarley and Hobson (1977) that may be called the "isolation process." This may well be

the neurophysiological system that Freud guessed must exist in view of the individual's tendency to concentrate, his capacity for self-observation (the observing ego), and the ability to create defensive patterns, particularly hysterical mechanisms and obsessive symptoms (splitting or dissociative processes). McCarley and Hobson believe that they have disproved Freud's theory of dreams. Actually, they have shown us the neurophysiological process that makes dreaming and remembering the dream possible. They have not explained the content of dreams, but they have disclosed the mechanisms that make possible our dreaming, our concentration, and other forms of thinking. There is a tendency toward growth, toward health, toward adaptation to the environment. It is the *self-actualizing tendency.* It is a factor in human life that will correct what the environment did not allow if a more propitious environment can be enjoyed. Research has confirmed that trauma in early years can be overcome if the environment is changed for the better (Dennis, 1938; MacFarlane, 1963, 1964).

The neurophysiological mechanism that is associated with the process of thinking is what McCarley and Hobson have studied. Thinking includes, however, several kinds of mental exercises such as fantasying, dreaming, problem solving, creative thinking, speculating. The process is made possible by the same neurophysiological mechanism that allows for the development of the "observing ego," the delusion (a fantasy), and concentration.

McCarley and Hobson report that the crucial mechanism setting off dreaming (and I would say, therefore, thinking) is in the positive stem in the back portion of the brain. This "mechanism" acts like a "generator" that evokes "outbursts," automatically, and through the midbrain this periodically activates the forebrain, which stores sensorimotor information. In dreaming (and therefore in thinking) certain "input" is inhibited so that the dreamer deals only with "sleeping pictures" without interruption. Thus this neurophysiological mechanism makes possible an "isolating factor," which is an "automatic process," being an aspect of the autonomous behavior program of every individual.

In the sexual area, notably Masters believes that sexual impulses automatically occur in both males and females at intervals during the night, and in men these cause erections every ninety minutes or so. Charles Fisher has told me that he has found this to be true in men, but he has yet to discover a repetitive sexual mechanism in women. These automatic arousals and neurophysiological systems are only now being studied and revealed so that we may have to revise many of our ideas concerning what goes on in the human body and the effects these mechanisms have on the mind. It is my impression that these discoveries will disprove Freud's developmental concepts and affirm other ideas that he proposed. It is obvious that this isolating factor would be necessary in the contents (conscious and unconscious) that relate to the defenses. It may well be that the instincts seek

expression and that when they are inhibited in life, a conflict is created that makes the individual feel he has many "incompleted tasks." This is the cause of the repetitiveness in dreams that we take as a manifestation of neuroses and psychoses. One must, however, revise the current ideas concerning the instincts and associate these with "good" impulses, i.e., self actualizing, self-preservative, and creative behaviors that are stifled in the course of relating to neurotic parents.

The repetitive trait as well as the isolating factor are characteristics of hysterical and obsessive mechanisms, and I count *denial* that is so prominent in the borderline patient as one of the hysterical phenomena. Freud noticed that hysterical blindness was a form of denial, and he made references to certain forms of frigidity as types of denial and as forms of hysteria. Frigidity and impotence were symptoms that Freud observed in his early patients many of whom we now recognize as having schizophrenic and borderline characteristics.

At the present time we become more and more mindful of memory as a dynamic concept, not a static concept such as the "memory bank." The "unconscious" or *the repressed aspects of the thinking process comprise a dynamic constellation affecting the present.* Not all of our patients' memories are associated with neurotic patterns. It is the bed of normal and creative thoughts in operation that enables the patient to find security in treatment

that requires change.[17]

Freud suggested that in all emotional problems there were “mnemonic fragments”; i.e., there were memories due to conflict over traumas. Although his time periods for defenses such as “repression” or “fixation” may be off, there is merit in the idea that the neurosis (or psychosis) begins with repression. A corollary is that traumatic memories bifurcate, i.e., part of them are put aside (repressed) and replaced by fantasies (“projective” and thus “protective” fictions) and symptoms. What we are not accustomed to do is to connect these mechanisms to part of the thinking process in current situations. We now know that traumatic memories are associated with “protective fictions” or fantasies; thus they are components of memories but the current situation stimulates memories and memories interfere with the interpersonal process in the current situation. Memories are components of the thinking system. *Thus identifications that are functions of acting out are associated with fantasies that activate acting out that is related to memories and to current situations.* Identification, to emphasize what I have said before, is a form of adaptation, a necessary kind of accommodation in view of the original family dynamics and the interlocking defensive system of the parents that arises as the parents use each other as transferential objects (objects of displacement), i.e., objects of projection. Identification is related to both conscious and unconscious thoughts. In our current theory regarding borderline patients (in fact, in any patient) we discard Freud's use of the idea

of an unconscious unconscious and recognize that it is conflict-laden thoughts and feelings that are frightening and unacceptable to the individual that he represses.

The Human Group and Communication

Various forms of thinking are the meat of our therapeutic focus. Individual therapy in my opinion is the treatment of choice for the borderline patient with the addition of group therapy. Family therapy is a revealing medium, but it is not a substitute for group therapy or therapy with peers, which is also important for the borderline. A few basic remarks about human groups and group and individual therapy are relevant here.

The human group is a group of members who communicate over time for the purpose of solving problems. Communication (a function of thinking! is attained by the exchange of information. Information is transmitted in any given situation where the member of a group may choose to interact by signals, symbols, words, or patterns that are transmitted, i.e., sent to another or to others. The *set* is the milieu where these categories of signals are transmitted, and the categories are called the ensemble or repertoire of the group. Mathematicians say that the amount of information is measured as the logarithm to the base of the number of alternate patterns. When *MX-Y,* then *X* is referred to as the logarithm of a system that processes it. Communication in

the group acts geometrically: as one person in the group puts in information, it stimulates others, and their responses increase the number of probability of response for the others because the more the possibilities for solutions to problems are suggested as each member adds to the information pool, the better the solution may be. This is not always true, of course. Groups can make harmful decisions, and these can be made by the majority of the members. In these cases however, the decisions are made on the basis of the neurotic communications of members in the group rather than on their rational reasoning. In the therapy group one of the duties of the leader is to help towards the goal of rational reasoning.

In living systems the observers, i.e., the group members, select variables from the infinite number of information units and relationships that exist. The unit of communication is the amount of information that relieves the uncertainty of members when the outcome of a situation with two equally likely alternatives is known. In group therapy, and in the individual treatment process for that matter, by way of information, several alternatives for a solution to a problem are offered. In order to act or to change the individual must choose one of those alternatives.

Information is the opposite of uncertainty. Thus to a social system (for that matter a community or a nation) information is the unifying factor creating the network which is defined as the *structure of the group.* The giving

and getting of information and the method whereby the members receive the information to set up further communication channels are the foundation of structure. The word “marker” has been used by cybernetics specialists to refer to those bundles, units, or changes of matter-energy whose patterning conveys informational symbols. Cybernetics as a systems theory refers to many different kinds of communication, however. For example, Indian signals, cuneiform writing, magnetic tape, arrangement of nucleotides in a DNA molecule, the pulses on a telegraph wire, or the verbal and nonverbal expressions of the members of a therapy group that convey information to the members for that particular small group. It is this latter that concerns us in the treatment process. In communication the marker moves in space, and this movement follows the same physical laws as the movement of any other sort of matter-energy.

The mass of matter-energy that makes up a systems marker significantly affects its information processing. It has been estimated that no system, living or nonliving, can process information at a rate greater than 2 X 1047 bits per second per gram of its mass. The random state or disorder of a system is known as its “entropy.” Order is the opposite and is known as “negative entropy.”

Communication is the change of information or its movement from one point to another over space. Communication is of fundamental importance in

that informational patterns are processed over space and the local matter-energy at the receiving point can be organized to conform to or comply with the messages. Matter-energy and information always flow together. Information is always borne on a marker. There is no regular movement in a system unless there is a difference in potential between two points, which is negative entropy or information. The word “system” means that there is a set of units with relationships among them by way of the communication that provides these relationships. The word “set” implies that the units have common properties, or interests. The state of each unit in a system is constrained by conditioning by or a dependence upon the state of the other units. A set of elements stands in action for the purpose of a goal.

In a therapy group interest and action between two or more members can be for one of two goals, problem solving or defense (resistance). Function is a correspondence between two variables such that a value of one depends upon a value of the other. This is called “conditionality” by group dynamics experts, and it is the basis of what Moreno (1934) spoke of as “pairing,” “triads,” "chains," and the like. Function means that there is a relationship between a number of variables in the system. In the human group this means the functional relationship between two or more people. A “state” in the system is a set of values on some scale (a measurement) that its variables have at a given moment. In sociology these are called “norms” and “values.” Moreno suggested that it is just such a scale that the individual uses in his

judgment to band with one or two other members for some particular reason to form a subgroup. He called this the “choice-rejection scale” in his system of sociometry. To him, this is the way in which one individual decides at any given point to join another (either for problem solving or for defense) to make a “dyad,” a “triad,” or a “chain.”

We have noted that the random units or the disorder of a system is “entropy.” In a closed system entropy increases, but actually there is no such thing as a closed system (unless the universe is one). It is true, though, that some systems are more closed than others. The family in which neurotic parents control is a system that is partly closed. The parents are the subsystem that keep the system together and see that it is organized in a particular way (this is the “housekeeping energy” according to some systems theorists). Negative entropy is organization. Negative entropy means functions or relationships between units. In the small group, which is what we deal with in psychotherapy, “relationships” refer to “who interacts with whom?” as Moreno pointed out. The structure of a system is the arrangement of its subsystems and components in three-dimensional space at a given moment in time. In group psychotherapy there are several types of subsystems. For example, the individual is a subsystem; two or more persons interacting over a period of time are a subsystem. Moreno (1934) has explored the dynamics of the small group in his presentation of sociometry. Simmel in 1908 wrote the first definitive treatise on small-group dynamics.

Simmel's work has been translated by Wolff (1950). Other important studies on various aspects of the small group have been done by Homans (1950), Bales (1950), Bales and Strodtbeck (1950), Asch (1952), Bales and Borgatta (1953), Cartwright and Zander (1953).

The communications of the borderline patient will at times be cryptic, and one must learn to translate the information at points where it is likely that the communication will be received by the other with the least resistance. For example, Kurt Blau told me of his own depressive moods by first talking of one of his clients (when he was practicing social case work before he received psychoanalytic training). Since the message was not about himself but about a client, I talked of the client's depressive problem. It was four years later that I was able to speak to him of his own depression and relate it to some of his mood swings. When in a depressive mood, nothing that Kurt did would please him. It was a direct expression of an "identification with the aggressor." This was not a deep depression that immobilized Kurt—not at all. He was still doing a massive amount of work, carrying many family responsibilities; yet he had the desire to "get away from it all." He felt trapped, and although he was now very successful in what he was doing, he, nevertheless, did not know whether his work was really what he wanted. He might like another field, but he is not now free to pursue what he would like, even if he knew what that would be, because he is so burdened with family responsibilities. This kind of reaction is multidetermined and very

complicated. Part of the problem is that the patient cannot stand success. His guilt is still active and must be analyzed further. Self-reproach is a hostile gesture toward the successful self, a need to "tear down." We see this kind of dynamic in schizophrenic patients as well, but the borderline's reactions are not as severe as those of the schizophrenic.

I was interested in a paper by Schwartz (1978) reporting on the communications of an institutionalized schizophrenic woman who was rambling on "like a word salad" mumbling, "teddy bear," "bed," etc. When the head doctor came near her on his rounds, he shouted, "Young lady you ought to find out who you are!" The patient "became normal" and said smiling, "Yes —I do often confuse my identity with my bed, my table, my teddy bear." (This can be a depersonalization in the face of an interpersonal encounter.) We very often see schizophrenics who "clear up" from such episodes and have periods of clarity for many hours and some clear up for many years. It is the *meaning system* in the communication that is important.

The borderline patient too "clears up," but he also has depressive feelings, panics, schizoid states, paranoid attitudes, explosive episodes, antisocial episodes, and sadomasochistic and "infantile" behavior. I see similarities in traits such as explosiveness, "infantile and narcissistic behavior," and antisocial behavior. There are similarities, too, in passive-aggressive, sadomasochistic, depressive, manic, and explosive episodes. What

we call “narcissism” and “infantile behavior,” however, is often *withdrawal behavior* and self-preoccupation in response to great anxiety in interpersonal situations or in anticipation of anxiety-provoking interpersonal encounters. In a protected environment or when the situation is at a minimum of “to-do,” the patient seems quite “normal.”

The patient indulges in a “word-salad,” and when the therapist says, “Young lady, you need to find out who you are,” she breaks into rational talk and says that she confuses herself with her bed, her teddy bear, the clouds, and so forth. One must wonder why she can clear up so readily and speak normally and tell us what she does. This is a manifestation of ego integration. The “word salad” is actually a part of her fantasy, her masochistic, depersonalization fantasy into which she lapses after emerging temporarily.

Another patient says to her therapist, “You are unreal—you don’t exist. I can’t stand your dead feel, your fishy eyes, your calculating mind. How can it be that I chose you instead of the others who want to be friends, who want to work with me.” The therapist says that not long ago she felt that way about herself. The patient then talks of birth, relating a “beautiful” fantasy of a sea horse having millions of babies but only a few survived. The therapist thinks of “the self” and a “shattering” or a fear of attack or disintegration. If I were the therapist, I might think of masochism, the “beauty of her fantasy being an idealization of a traumatic experience and her masochistic response to other

people. Then it would be an acting out with idealization of the fantasy as a representation of her identification experience.

The catatonic young woman responds to the therapist after many days of silence saying that he should abandon her, send her away, destroy her, put her to death. (Is this a masochistic response to his plea, "I want to help you! I want to talk to you. I want to be with you"?) The woman then looks away in despair. Weeks pass, and finally she makes "cutting" gestures in front of her abdomen. He thinks she is trying to cut the umbilical cord. I, though, might think that she is telling him of her fears of sex, her sadistic fantasies about sex, and her masochistic feelings, which are her only avenue to sexual feelings. The therapist probably realizes that she is using him as she may have been used—she is acting like the parents. The patient then finally makes a "date" with the therapist. Her tear-filled eyes and her plea for the date is a masochistic maneuver. I believe this is an acting out of a "beating fantasy." I do not say he should not have made the date. She says that his "hello" on the wards is "phony." Why does she say phony? Is this a trap for the therapist? It may be. This may have little to do with "self" in a developmental sense. It is an exposure of a masochistic role on the masochistic self; she is herself; it is a manifestation of *low self esteem.* The girl must beg for a date, must evoke the guilt of the other. The patient is acting out masochistically as she did with her parents instead of being a person who is recognizing her ego capacities within the confines of the therapy situation.

As we have mentioned, schizophrenics and borderlines do act out with the therapist in the beginning phases of therapy in an attempt to involve him in a sadomasochistic pattern, thus knocking him out of his therapeutic role. In the second phase we outline this pattern and emphasize the transferential significance. By the third phase this acting out of the transference has ceased, and more direct transference manifestations are evident. Has the analysis made up for ego defects? Or has the analysis been such that the anxieties of the patient have lessened considerably and he can now address the therapist directly without acting out as he did with his parents? I believe it is the latter. Has the patient finally adjusted to the non-acting-out atmosphere of the therapeutic situation so that his acting-out pattern is reduced through lack of stimulation—a deconditioning process? I think so.

The "good side" of this acting-out maneuver in the first phase of treatment is that the patient's behavior is an indication that he is developing a relationship with the therapist. In the case of the borderline and schizophrenic it is a sadomasochistic relationship, and he will try to trap the therapist with acting out—the pantomimic transference (PT)—but he must accept this relationship. In the case of the catatonic young woman in the hospital the therapist realizes the hazards, but he must take the chance that he will be able to tell her eventually that while he wants to be of help, he cannot conceive of having a relationship where he would injure her, have contempt for her, throw her out, and so on. He will have to let this message

come across to her in some kind of acceptable words at an appropriate time so that she cannot possibly feel rejected. Or if she does, she will recognize with him that she knows she cannot have sexual feelings without having these sadomasochistic fantasies and acting them out in some way.

This pattern is the result of the group interaction in the family with the neurotic parents as the controlling agents in the family group. In my opinion, the patient who acts out in this way is not a suitable member for a group at this point. She should be introduced to a group after she has worked through the pantomimic transference (PT). Freud (1916) wrote in his paper "Those Wrecked by Success" of the problem of guilt and the self-destructive dread, or obsessional worry, "signal anxiety." "You are not good enough; you are not going to succeed" is the internalization of the destructive identifications, the extensive kind of PT that is manifest in the schizophrenic patient. But each in his own way acts out the transference in the beginning. My patient Harold Hemple, for example, was nearer to the neurotic side of the spectrum or continuum than another patient, Sonia. He came into therapy with a very restricted mien. He was so precise, so orderly, so withdrawn, so "proper" as to look almost manneristic when he walked. His man/woman drawings are reproduced in Figure 1.

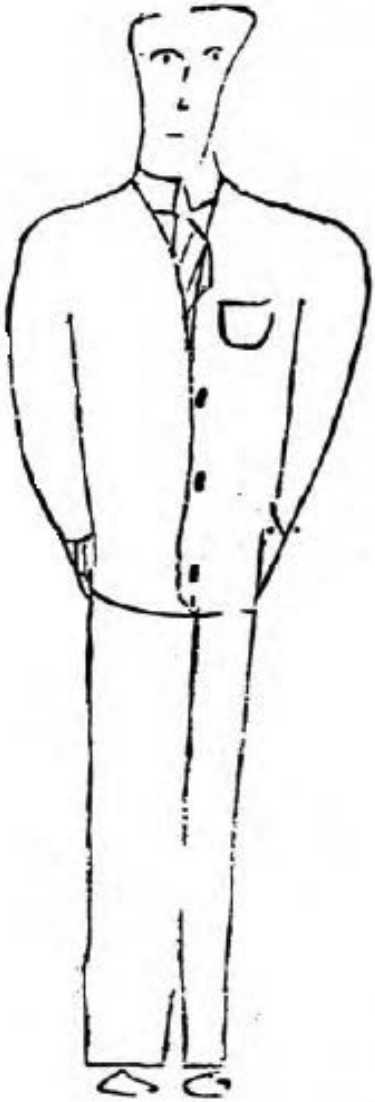

Figure 1.
Drawings by Harold Hemple, January 7, 1962.

Harold looked like the man in this drawing when he first came to therapy. He was restricted in his walk and his talk but very precise in all that he said. He had a fantasy of himself creeping into the session like a cringing animal. Interpreting the drawing he said: "The woman is angry. The man is just defending himself. He can see other things in the world, but the woman is so obsessed with anger that she cannot think of much else. The man would like to have sex with someone; she is too upset and hostile. That's like me—I would like to get married, have a girlfriend, but I seem too afraid, too particular, I'm not easy in the presence of women. I have to have a girl who is refined, and I haven't met too many of that type."

Harold was very masochistic and would become so in the presence of women, but then he would have grandiose fantasies as a defense, and he was scornful of most people. He did not want a male therapist, however, because that would be too threatening for him—he could not compete with men. The woman was the dominant figure in his family (the man was dominant in Sonia's family). The father was passive in my patient Harriet's family (in Sonia's family the woman was passive). In the family was the interlocking neurotic relationship between the parents, i.e., the interlocking defensive pattern. Harold crept into the analytic presence. In that sense he acted out his fantasy of being a beaten animal.

Theoretically speaking, I believe that masochism and self-castigation are an acting out of the "beating fantasy." I do not know whether all children have beating fantasies, but I do know that when the family situation is such that, over a long period of time, the individual feels constantly demeaned, he persists with his beating fantasy, and we see it enacted in a great variety of ways. The persistence of the fantasy is an indication that the communication system has had a demeaning effect upon the child over a long period of time.

If the Family Is the Seat of the Problem, What of Family Therapy?

The study of the family has been a focus for psychoanalytic theory and practice in the treatment of neuroses, psychoses, and borderline cases for almost half a century, and out of the old child-guidance clinic has emerged the "family-therapy" concept. The child-guidance and child-therapy fields were the source of the ideas that parents have a much greater influence on the neurotic behavior of the child than Freud was willing to admit. It was in the social agencies and the child-guidance clinics that the concept of family dynamics was developed. This concept requires a knowledge of social theory as well as a theory of dynamic psychology if we are to understand our patients, including borderline and schizophrenic patients. Family therapy is a form of group therapy. All people, with few exceptions, are members in life of several groups, and often these groups are at odds from the point of view of goals. Family therapy has been suggested as a therapy of choice for the

"sicker" patients, which group includes the borderline patient.

There has been a controversy in the past twenty years between those family therapists who follow Freud's developmental scheme and those who use dynamic concepts but are "group" or sociologically (systems) oriented rather than psychoanalytically inclined. Haley, an example of the sociological group, espouses a number of concepts that I shall mention. Some of these concepts seem valid, while others show the tendency to try to merge the individual into the group so that the individual's autonomous behavior is ignored. Haley (1971, 1976) writes, for instance, that a person exhibiting psychiatric symptoms is a person who has adapted to a unique family situation. This is certainly true. He then continues that this orientation raises the question of the unit to be studied in therapy, and he suggests that *the family* should be considered the patient rather than the individuals in the family. To my way of thinking, the latter proposition is an anthropomorphizing of the group. Haley argues that we must study the social context of the individual since he is adapting to the social situation, and one could certainly agree with such a statement. But then he states that if one changes the context of the group, one changes the individual. It was assumed by Freud and others that psychiatric problems represent maladaptive behavior, but in Haley's view the behavior is adaptive. I can agree that the behavior is adaptive, albeit defensive. When Haley infers, however, that a change in the group will ergo make a change in the individual, then he is using

a simplistic concept and ignoring the dynamics of individual change. Change from neurotic to normal comes about slowly. Resistance to change is strong even when the individual wishes the change to take place. This is particularly true for the borderline patient. Change occurs over time, but it will occur.

Haley suggests that the dynamics of families who have a psychiatric patient are different from those who have no such member, and in this we can agree. But he then asserts that if families containing a psychiatric patient are different from other families, the social context must be different, and the social context must change for the individual to change. The entire orientation of therapeutic intervention hinges upon these factors. I would suggest that the patient can change by *leaving the family,* and he can change *before* other members change even when he remains in the family. Other members may then change in behavior if they wish to maintain their relationship with the person who is receiving treatment. But the therapist must be ever alert to the *nuances* in the dynamics of change. It is a fact of life that certain family members will bring great pressure to bear on the individual who is in therapy to give up therapy and to go back to old neurotic habits. Family therapy does not eliminate this pressure automatically.

Haley raises several significant questions:

1. Are families that contain a member who is “abnormal” different from families where all members are “normal”?

2. Is a family that has a member having one type of psychiatric disorder different from a family that has a member with a different type?

3. Is one part of a family different from another part? That is, is the parental relationship with an "identified patient" different from relationships with his siblings?

4. Are parental relations with extended kin different in different families?

5. Does a family change to a different system after an individual in the family has had treatment or after family therapy?

There are some answers to these questions in results of family studies that are of importance to our understanding of the borderline patient—for example, the following:

1. "Normal" families have members who are less hostile, aggressive, dependent, immature than other families. (Borderline patients, as Grinker's research has shown [Grinker *&* Werble, 1977; Grinker, Werble, & Drye, 1968], live in families where hostility and aggression are ever present.)

2. In studying family structure the emphasis is on whether family members fulfill their roles properly: the father role, the mother role, the role of child, and so on. (In any psychotherapy we try to ascertain in what way these roles are fulfilled, whether in neurotic or normal ways. It is understood that when we use the word "normal," we mean families containing all members who are comparatively mentally healthy. Perhaps there is no truly "normal" person.)

3. Normal families communicate more clearly, exhibit less conflict and discord, have fewer disagreements, have more stable coalition patterns, and shift to different patterns of behavior if the setting requires this more easily than families that contain emotionally disturbed members. The latter families are rigid and resist outside influence to change. (It is interesting, too, to realize that when disturbed family members do seek company in other groups, they turn to groups that have similar destructive members as their own families.)

4. Normal families solve problems more quickly than abnormal families and with less "noise."

Psychoanalytic Concepts To Be Discarded in Treating the Borderline Patient

In studying the borderline patient and in reviewing some of the material related to the early stages of development, which is the period that most analysts say is the "fixation" stage for the development of borderline conditions, it occurs to me that the following is a partial list of the psychoanalytic concepts that we shall have to discard:

1. The early interpersonal state of the infant is "objectless." An autism exists where there is no distinction between self and objects.

2. At birth the psychic apparatus is in an "undifferentiated state."

3. Psychic representations of other people are at first partial, i.e., breast, face, and so forth.

4. The mother is the only emotionally charged object for the infant in the first two years of life.

5. The primary process is the bedrock of the intruding fantasies of the patient.

6. In response to the smile of the mother the infant smiles in return, and this imitation is the precursor of the later psychic process of identification, the basis of much ego development.

7. Toward the end of the first year, the child has "separation anxiety" in the mother's absence and this is associated with a "fear of strangers" ("stranger anxiety"), which is the beginning of recognizing objects as such. Defenses against painful stimulation begin to develop.

8. In its primitive functioning the ego follows the model of bodily functions, i.e., the mind introjects, "takes in," as in nursing, what is pleasurable and seeks to ward off what is unpleasant, or to eject, evacuate, (externalize) the impressions of unpleasantness.

9. During the second year the infant develops the capacity to be alone.

10. In the early stages of development the infant cannot know how helpless he is because his needs are satisfied as if by magic, as if he were omnipotent. Later when he realizes that he is helpless he attributes the omnipotence to his parents and he thus begins to idealize them.

11. Due to their influence on superego development, social institutions can be considered elements in a biological frame of reference.

12. In everybody's mind there is a bed of unconscious, underlying, primitive, part-object fantasy remnants persisting from the distorted perceptions of early life.

13. In treatment there is a temporary "splitting of the ego" into an "experiencing ego" and an "observing ego." This is normal, but there is a more permanent and pathological form of "splitting of the ego" in the process of dissociation, seen in such conditions as fugue states, multiple personality, fetishes, and many other types of perversion. There is a similar "splitting" in the borderline patient's psyche.

14. Identification is an automatic, unconscious process whereby an individual becomes like another person in one or several respects. It is related not only to maturation but also to learning, mental development, the acquisition of language and speech, the adoption of interests, ideals, mannerisms, and so forth. The individual's adaptive and defensive patterns are a function of identification with either loved, admired, or feared persons. In order for identification to occur, there must have been enough psychic development so that the individual can distinguish himself from others, i.e., self-representation must be distinguished from object representation. This does not occur before the age of 10 months and rarely until 16 months; the final separation process occurs at age 3.

15. The mother must act as an "executive ego" for the infant.

The fifteen premises that I have presented here are all used in present speculations concerning the borderline patient. If they are all erroneous, one

can imagine that our ideas of the development of borderline personality will have to change considerably.

I would like to suggest that there is no primary process in the sense that Freud thought of it. The thinking of the borderline patient that has been called chaotic, disconnected, in various degrees has a relation to the patient's sadomasochistic identification fantasy. In fact, these bits and pieces are part of the fantasy that is evoked by *intense anxiety* either in interpersonal relations or due to certain types of thoughts that are fearful, dreadful, or both. In disguise, the ideas are symbolized, broken up, distorted, and the fantasy parts are dissociated, a masochistic act.

Freud felt that the patient was finding atonement in the masochistic illness when he would not allow himself to enjoy success. The "need for punishment," he felt, was one of the worst obstacles to treatment, Freud finally, in "Analysis Terminable and Interminable" (1937), located the roots of this problem in Thanatos (the id). It has been suggested that this discouraging aspect of treatment in these cases (the borderline is a case in point) was one of the factors in Freud's formulation of the death instinct. The concept of Thanatos made masochism a derivative of a constitutionally intensified aggressive drive. Another major reason for Freud's solution concerning that aspect of the superego "as yet unclear to us" (i.e., the connection of the superego with the id) was that Freud chose to avoid any implication that the

parent had a major role in the organization of the patient's emotional problem. The interpersonal theory would suggest a conditioning factor over time in view of the repetitiveness of the parent's neurotic pattern and the need of the parent for the child to play a neurotic role. This possibility was vehemently denied by Freud. Would the patient's masochism be less if we could assure the parent that the child is "whole" rather than "defective"? I doubt it. The masochism and the related sadism do not derive from the instinct; they are man-made.

Chemotherapy and the Borderline Patient

There are those analysts and therapists today who believe that chemotherapy should be administered to the borderline because the chief seat of his problem is a chemically defective neurophysiological system. Chemotherapy does seem to enable the patient to tolerate the anxiety that he must feel when he finds it necessary to dissociate the parts of his fantasy. Or is it that the patient does have a chemical imbalance? I would opt for the answer that the dissociative process is part of the defensive system and has nothing to do with the neurophysiological system. Perhaps if parents thought that chemicals would cure, they would have a different attitude toward the patient, but I doubt it. Some theorists insist that if the patient were not defective, the parents would not have anxiety and would not "beat at" the child. Why then do the 40 percent of schizophrenics who do not show

chemical defects and perhaps 100 percent of the borderlines who do not, nevertheless have emotional problems? It is the psychotherapeutic process that is essential and important for the borderline, whatever the cause of his problem. There are times, however, when chemotherapy can be useful, particularly for depression and intense anxiety states.

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Notes

16 See A. Wolberg (1973, pp. 211-213) for the origin of this dynamic in the parent-child relationship. In the example cited it is the mother who is involved in the development of the pattern, but it can easily be the father too who evokes this behavior as in the instance of Frank (p. 214) and Lisa (p. 208). As one will see from the material these patients produce in the sessions, it is the identification with these controlling and sadistic parents that the patients act out that interferes with making an adequate adjustment, and it is just this problem that is so poignantly denied while asking and pleading for help. This can be a frustrating experience for the therapist who is treating the borderline if he has no adequate therapeutic technique to deal with this defense.

17 Freud had a concept of an unconscious unconscious i.e., a bed of drives and impulses. The id was the mental representation of this Ucs-Ucs. The defenses went into operation due to the anxiety that these raw impulses stimulated. Society would not allow these raw impulses to be discharged. There were ideas associated with the id, which were what Freud called innate ideas (a racial heritage as it were). Later Freud felt that the ego too had an unconscious level. But the ego was based on experience in this world, a part of the id split off to form the ego, which was, in fact, a mental reservoir of the effects of the experience with objects. The superego was a split-off part of the ego. Actually, both the ego and the superego were derived from part of the id that underwent a metamorphosis, i.e., that part of the id that dealt with the outside world. Freud was trying to conceptualize the genetic process in mental terms in his concept of the id since he noticed that there were not only repetitive impulses coming from the individual organism such as sexual impulses, but also there were repetitive defensive patterns. He conceived of the repetition compulsion as a factor in the constitutional equipment. We know that there is this innate schedule in development and in life itself, but we also know now that the two systems—conscious and unconscious—so far as mental life is concerned do not run parallel to physical development. However, it is true that physical development has an effect upon how the person conceives of himself and how he reacts to people. From what we know today from modern studies, it seems more reasonable to conceive of several systems operating simultaneously in the human body but not necessarily in a "parallel" sense as Freud thought and postulated in his developmental scheme. The concept of *memory*, however, is primary in any theory of mental life. It has a prime place in Freud's scheme of the unconscious and of the conscious as well. Freud confused this concept with his idea of psychophysical parallelism in the various stages of development so that such concepts as "oral," "anal," and with mental equivalents is not a valid theory. These concepts, however, are applied in the case of the borderline patient by most theorists today. The intricacies of the body and mind are beyond my comprehension and beyond that of the scientists who are working in these areas. In other words, scientists still have much to learn and are marveling at what they are learning. Two concepts are relevant to our needs in relation to understanding the "systems" and their operations in regard to specific types of emotional syndromes: *memory* and *the integration of experience* or what the psychoanalyst has called internalization (of objects!. We shall have to look upon these phenomena in a somewhat different way than Freud suggested. In this realm of multidisciplinary thinking it has been very easy for psychoanalysts to misapply concepts from one field into another. The important point is that while man is a group animal, he is, nevertheless, an individual—and this has presented a dilemma to many theorists. We must understand both individual and group phenomena in the treatment of all patients. Whatever the

experience in the environment has been it is nevertheless *the individual who must cope with the correction of his behavior.* The individual with his fears, dilemmas and conflicts is the ultimate focus of psychotherapy.