# BRIEF PSYCHOTHERAPY

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# Brief Psychotherapy

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## Brief Psychotherapy

Short-term therapy can be effective with the borderline patient even though certain borderlines benefit only from long-term treatment; but the borderline patient, for many reasons, does not get into a long-term treatment regimen readily. In the first place, it is difficult for him to establish a relationship of trust; in the second place, he is so anxious that unless he is treated in a special way during the first phase of the relationship, he will surely leave before he can appreciate some of the psychodynamics and psychopathology of the problem in a way that he can benefit from such knowledge. If he goes to a clinic because of limited financial circumstances, he must be encouraged on a practical level to take steps to change aspects of his reality situation so that he can improve his economic conditions and thus have a better standard of living as well as then be able to afford a modest fee.[19]

Short-term treatment to be effective for the borderline patient should occur on a once-a-week basis and be in the range of twenty-five

to thirty-two sessions, with perhaps two weeks of vacation after fifteen sessions. This time basis is for outpatient treatment. This does not mean that crisis intervention will not be helpful to the borderline patient as it is to others. However, the patient seldom comes in to the outpatient setting in a crisis; rather, he comes with vague complaints such as "I don't know where I'm going," "I feel empty," or "I fear that I may hurt myself or someone else," and the like. It is the schizophrenic patient who actually does hurt someone else and then is caught. The borderline patient can get into trouble with the law if he is using drugs or alcohol, but he seldom injures others in a homicidal way. He is destructive in a sadomasochistic way but is inclined to fear his own and the destructions of others and to set up some kind of controls, often asking friends to help him.

Some borderline patients when they are in a state of emergency go to the outpatient department of a general hospital; others go to a mental hospital for help. Their stay in the hospital is temporary, and the treatment is generally confined to the administration of a drug. As a rule the borderline does not seek hospitalization on his own; he is usually accompanied by a friend or relative who has been coping with the patient for a number of days and who cannot do so longer. Most

borderline patients, however, are not hospitalized; they seek out friends or relatives when they are in anxiety states and manage to overcome the anxiety by either talking out their fears or managing to quiet themselves, using the friend or relative in their fantasy as a protective figure. Most borderlines who actually seek treatment are managed on an outpatient basis, either in private offices or in a clinic. I have seen cases where one session on an outpatient basis has been of great help to the borderline.

A book edited by Lewis R. Wolberg (1965), *Short-Term Psychotherapy,* contains many helpful articles on principles and practice in short-term treatment. His more recent volume, *A Handbook of Short-Term Psychotherapy* (1980), reviews current practices and delineates an original technique by Wolberg of one, two, or three sessions using hypnosis and tapes with suggestions for relaxation. In the 1965 volume, the patient I described was a borderline patient. The report by Helen Avnet in the same volume (pp. 7-22) details a research project financed by the Group Health Insurance organization in New York City indicating how short-term treatment was effective with the more disturbed patients—schizophrenics, borderlines, character disorders, and others. Nine sessions was the time period for this study.

The work was done by psychoanalysts who were dubious about a favorable outcome; thus the effort was “dynamically” oriented. The results were rather startling in that the patients, on follow-up, had gained a great deal and the benefits were lasting. Lewis Wolberg’s chapter in that book describes in succinct terms the theory and methods of short-term treatment from the psychoanalytic point of view.

When we use the phrase *short-term,* we have several kinds of treatment in mind: crisis intervention, behavior therapy, brief supportive therapy, and dynamically oriented psychotherapy. One example is the short-term therapy that Sifneos (1972) describes,—an analytically oriented, anxiety-provoking type of therapy of six to nine sessions based on the idea that tension is necessary for the working-through process. In this type of therapy the aim is to work through some aspect of the oedipal problem. Sifneos selects patients who have certain characteristics, such as (1) the capacity to develop a relationship quickly, (2) a past experience of a meaningful relationship, (3) good intelligence, (4) a ready acceptance of interpretations. Usually when brief therapy is done with borderline patients, it is not possible to select individuals with the characteristics

that Sifneos suggests. The therapist can. though, relate to what is called in psychoanalytic parlance, the “oedipal problem.” This problem, however, must be defined as “trouble with both parents,” relating the family dynamics not only as these refer to sexual feelings and fears, but, also to aspects of the “superego,” such as guilt, depression, certain value systems, and role behaviors, particularly acting out and its significance.

## The Selection of a Small “Area” That Can Be Worked Through

In every brief treatment of one or two to six or seven sessions, which is the kind of brief therapy that Sifneos does, it matters little what the diagnosis actually is. Sifneos is obviously an astute clinician who can put his finger on a problem area that can be worked through, and *that* is the important point in brief therapy with any type of patient. The first step is to interview the patient and decide *what aspect of the larger problem can be worked with in a brief period.* In my opinion, one must be a very experienced therapist to be able to select such an area. Intuition will often help the inexperienced person find a focus for the work to be done. This was apparently the case in the Betz

(1962) and Whitehorn and Betz (1960) studies, the *A* doctors having more intuition and "therapy sense" than the *B* doctors in treating schizophrenics. It was obvious that in neither of these groups did the doctors have a great deal of training in managing the therapeutic process. We can learn from these studies, however, about the way to establish a working relationship with a patient (any patient). We remember that the *A* doctors, i.e., the more successful treatment personnel, more frequently grasped the "personal meaning of the patient's behavior beyond mere clinical description" and they "more frequently aimed at modification of adjustment patterns and constructive use of assets rather than merely symptom relief or correction of 'faulty mechanisms'"; they "participated more actively in discussions, expressing honest disagreements"; they set realistic limits and "avoided passive permissiveness or interpretations of behavior in an instructional manner." Theirs was a dynamic orientation. In brief therapy with the borderline patient, I believe, this is the theory of choice. The approach to the patient should be the same for the borderline patient as the *A* doctors used with their schizophrenics.

In any treatment endeavor it is important to have a diagnostic understanding of the person one is related to in the therapeutic

process. Therefore, I put very little confidence in behavior therapy for borderlines—except as it may be used as an adjunct to a psychoanalytically oriented dynamic process. The psychoanalytic postulations should be consonant with current modern knowledge of human behavior and not based on outmoded aspects of orthodox developmental theory.

## Communicating with the Patient

In establishing a relationship with the patient it is important for the patient to know that he is understood. This is accomplished by speaking to him in dynamic terms, using everyday language. The therapist must convey to the patient in adequate and appropriate communicative style that he senses the meaning of some of the patient's behavior (conscious and unconscious) and his reasons for seeking treatment. The therapist must then select from the preconscious material a theme that most closely represents what bothers the patient, and using material easily available for discussion, he makes a definitive statement presenting the theme. This means that one communicates to the patient some of his possible repressed feelings and thoughts, applying these to an appropriate sector of the

patient’s current circumstance. Repression and other defenses are operating to reduce the anxiety that the patient might feel if he faced certain aspects of his reality situation. One might say to the patient who came in because he was afraid that he might choke his girlfriend something like the following:

> Th. The feeling stirred you up and made you fear you might really hurt her. I wonder if you were angry at her. It probably wasn’t an impulse out of nowhere.
>
> Pt. No, I wasn’t angry, although I wished she had been more pleasant that evening.
>
> Th. Well, you don’t like to be critical, I can see that. Is it because you may feel that you shouldn't?
>
> Pt. Yes, I've been taught that one shouldn’t be critical of others, but I often do feel critical.
>
> Th. Well, many of us often stray from what we’ve been taught. But I can see that it shook you to feel you have the potential for hurting someone. Perhaps we can look into the excessive guilt you have when you feel critical of another person.

The patient’s defenses are against the very goals he seeks in psychotherapeutic treatment. Basically, the borderline is an angry person, often presenting himself, as we have mentioned, as “help-

needing," yet utilizing all sorts of resistances against receiving help. This way of relating, as has been emphasized throughout this volume, is sadomasochistic and oppositional—the mode of a passive-aggressive character that is the typical pattern of the borderline. We have noted, too, that the borderline patient always has an acting-out problem. Our patient who may have felt like choking his girlfriend undoubtedly acts out with her in some kind of hostile way, and obviously she participates in the sadomasochistic exchange. As we know, the borderline patient makes use of denial, repressive mechanisms, and projective defenses to a much greater degree than the neurotic. This is a function of his use of projective identification, i.e., identifications with parental figures that are denied and acted out in a compulsive way.

## General Dynamics Found in All Borderline Patients

In our initial statements to the patient, as a possible focus for short-term treatment, there usually emerge two or three themes, even though each patient is unique—like each thumb print is unique, or each snowflake is unique. Despite the many individual differences, there are some general dynamics that are operative in all borderline

patients. I outlined some of the differences between the neuroses and psychoses and the borderlines in my first paper on the borderline patient (1952), suggesting the following: (1) Reality testing is intact. (2) The patient is sadomasochistic. (3) He has minor mood swings. (4) His sadomasochistic behavior occurs in a kind of cyclic manner, acted out within interpersonal relationships. The latter is done somewhat as follows: He submits, or demeans himself in his relationships, and he idealizes the other (Kohut has called this as an aspect of the developmental process in infancy, but I consider it an aspect of the sadomasochistic defense). In addition, he has grandiose fantasies. The idealization lasts until the therapist or the other person makes a move that the patient does not like, and then he devalues the person, perhaps not verbalizing this in the beginning but nevertheless acting it out and using his disappointment as a defense and an excuse for his feelings of anger. At the same time he feels exploited, demeaned, drained, and depressed. He acts out in whatever way is customary for him to revenge himself on the other, for he is not simply angry, he is revengeful. He may break off a relationship; he may get drunk and have a fight; he may become sarcastic with a friend; he may engage in a homosexual episode, humiliating and degrading the partner and then

himself; *he* may assume a Don Juan pattern with a member of the opposite sex or *she* may play a “Dona Juana” role. If married, he will fight with his spouse, beating at the spouse verbally. Occasionally one spouse may strike the other, but usually this does not occur: most often, they express rage in words and in a punitive or retaliative way. There is then a hiatus or what might be called a “resting period,” and later the whole pattern is repeated.

When this process occurs in the analytic situation, as it inevitably does, the patient tries to throw the therapist out of his analytic position and assign him, in transference, to the role either of parent or child, for he is acting out with the therapist a pattern that he had with his parents. In this acting out of the transference, the patient usually lays bare his problem—albeit in the context of denial. His acting out with the therapist, or his “acting in,” if one prefers the phrase, is a replica of the behavior he learned in his relationship with his parents. Often he teases, he is angry, he tries to make the therapist feel guilty, and *inevitably he maneuvers to have the therapist become a participant in the acting-out pattern.* I see this as a need to use the therapist as the patient was used by his parents, i.e., as a projective object, creating an interlocking defensive system, a form of projective identification

(Wolberg, A., 1973, 1977), an "acceptable" way of expressing aggression.

With respect to the patient's problem and how this is reflected in his behavior with the therapist and with others, one must understand, as I have often mentioned, that *projective identification* is a basic defense predicated on childhood experiences with parental figures and the "identification fantasy" relates to the acting out.

It is especially important in doing short-term therapy with the borderline to recognize that the patient (and perhaps all patients) is suffering from identifications that are formed *over a period of years* and not merely derived from some infantile trauma that occurred in a "narcissistic" period. The "childhood experiences" with neurotic parents, thus, are not confined to one particular developmental period but to events that are repeated with the parents during the entire relationship. It is not wise, therefore, to follow Melanie Klein's theoretical reasoning with regard to projective identification. I see this problem in the context that Freud indicated in his essay on "The Uncanny" when he described what I called an interlocking defensive relationship (Wolberg, A., 1960, 1966, 1968, 1973, 1977) between a

man and a woman. Freud touched upon the acting out of a particular wife (she was flirting with another man including touching his thigh while talking). This was, it seems, an “unconscious” means of making the husband jealous. The husband, in turn, then felt “justified” in condemning the wife. In his essay Freud seems to have ignored the role of the wife, considering her behavior harmless and dubbing the husband “sick” because he interpreted her behavior through his own projection. I see this behavior on the part of husband and wife *as an interlocking defensive system*—each one in the marital pair using the other to project upon and thus to deny certain neurotic impulses and behavior in themselves and to justify their particular behavior. It is this type of interlocking defense that is the dynamic in projective identification, but the problem, in my opinion, did not start when the baby was born with excessive oral aggression, as Melanie Klein thought.

I agree with those English and American authors who feel that the mother must be neurotic for the child to be neurotic, but I also believe, as I have repeatedly pointed out, that the father is involved, too, *right from the start* and that he is an active part in the interlocking defensive relationship with the mother. He too involves the children in

his defenses. As the children come along, they are gradually used in the family system as projective objects. This family dynamic described by Szurek and Johnson (1952) should be understood in this way, i.e., in the sense that interlocking defensive relationships are set up as the patients promote acting-out behavior in their children in order to use the children as objects of projection. The communication system of such families has been described by the Jackson group and their associates (for example, see Jackson, 1957). One must accept the idea, in my view, that all *acting out* is based on identifications with parental figures and that the parents promote the acting-out pattern; in fact they demand it, so as to maintain their own neurotic homeostasis. The parents, in denying certain aspects of their neurotic identifications with their own parents, project their hated or rejected parts or roles onto their children. By means of both verbal and nonverbal communications, and the use of punishment and reward, they enforce roles onto the child so that he acts out for them. It is not that they themselves do not act out as well; they do (Wolberg, A., 1960). The acting out is a patterned role that is not evoked in infancy due to the child's inability to control destructive impulses; it is developed over time due to the anxiety-laden insistence of the parents who beat away

at the child in an obsessive manner until he gives in so that, against his will and better judgment, he begins to play a destructive sadomasochistic role. At that point he is sucked into the interlocking defensive system that pervades the family and as he uses others as projective objects in his defense, the “other” becomes involved (if he is prone to do so) in the dynamics of projective identification.

To reiterate my thesis, parents provoke identification behavior in the child in the interests of their own defenses. They each project roles onto the child that are associated with an aspect of their own identifications with their parents, roles they wish to deny (Wolberg, A., 1960). The child fights against the identification (Wolberg, A., 1977), but in the end he must succumb. Freud called this “giving in to the other,” and he noted that this trait is related to a homosexual trend. One can find in the sadomasochism of the borderline patient a latent homosexual component related to the parents’ tensions concerning their own sexual roles and the anxieties they experience when their children act in a sex-appropriate way with others. The parents then exercise aggression and guilt-provoking behavior as a way of controlling; this normal behavior and then deflect the child into perverse channels. I would say that the trend Freud spoke of “giving

into the other" is a masochistic defense and part of the perverse trend, the masochism and the projection in the fantasy being the defense against recognizing the patient's sadism.

The punitiveness and the guilt-provoking behavior of the parents create sadomasochistic responses in the child, for in this process the parents use their children in perverse sexual ways evoking neurotic sexual patterns. As they project their perverse feelings onto the child, they enmesh him in perverse sexual interchanges. In the borderline patient aggression becomes tinged over time with sexual and revenge feelings due to the child's frustration. These feelings, in turn, are related to depression and the individual's basic feeling of having been rejected and devalued as a person in his own right. It is the revenge aspect of the anger that needs to be analyzed in longterm treatment and that makes the problem more complicated than the simple expression of angry feelings. It is various forms of revenge that have been mistaken for dependency of a childish nature. The individual is attached to the object of his revenge. Many view this as an early dependency that has been unresolved and thus has persisted throughout the years.

There comes a time when the child sees through the parents' defensive maneuvers and mentions this, but he is punished and told in so many words or ways that he too must deny. When he protests, which he does in the beginning, the parents say in essence, "What you say you see, you do not really see," thus decrying the child's reality-testing capacities and making him feel guilty for noticing the parents' neurotic behavior and commenting on it. Due to the parents' problems, aspects of the child's nonsexual self-assertion and his normal sexual behavior are threats. In their efforts to protect themselves, parents often lie (deny) to their children, as a defense. The children see through this but cannot accuse their parents for fear of punishment. Kolberg (1963, 1964, 1966, 1976) has done research indicating that children understand the false morality of their parents.

I have suggested (1973) that the borderline patient must give in to the parent as his identifications are impressed on him over time. I, therefore, believe we cannot look upon the borderline condition as belonging to a particular period in development since the parent has this sadomasochistic relationship with the child as long as they live together, that is, from infancy through childhood up through adolescence. As the parent and child have relationships, the parent

denies his role in the interlocking defensive neurotic relationship and forces the child to deny. The interlocking interpersonal process is defended by the sadomasochistic fantasy that depicts the relationship that the patient was forced to have with his parents. The fantasy, as I have said, is an *identification fantasy* and a defense against memories of the untoward experiences with the parents, who forced the identification through punishment and reward. Szurek and Johnson (1952) at the Mayo Clinic and also Szurek (1942) wrote that the *mother and the father unconsciously encourage acting-out behavior, which the child senses, and with which he necessarily complies.* Johnson (1949, 1959) noted that “identification with a parent consists of more than incorporation of manifest behavior of the parent; it necessarily involves inclusion of the subtleties of the parents’ conscious and unconscious image of the child. Unstated alternatives exist in the mother’s or father’s behavior in relation to specific behaviors of the child.” This is an indication that Johnson was aware of the “double bind." Johnson with her colleagues Litin and Giffin (1956) delineated some of the sexual acting out that parents promote in their children. We see all of these dynamics in the short-term treatment process.

## Twelve Basic Tenets of Short-Term Therapy

Obviously, in short-term therapy we cannot deal with the borderline patients' total problem and must confine ourselves to an area of immediate concern, even though the patient gives us much relevant material. It is this *parsimony in focus* that is our first concern and is of such great import in short-term treatment. The need to understand the borderline's dynamics, however, lies in the fact that the therapist is prepared for many of the manifestations of the patient's emotional disturbance and does not then respond in an untoward manner (countertransferentially) but can attend to the problem before him in a therapeutic way. The therapist must recognize the behavior but know that he *cannot handle all* material the patient presents.

In short-term treatment the fantasies and/or dreams should be used to understand *the meaning* of the patient's acting-out pattern and to determine what is the area of least resistance. We find this focus not only by listening to the patient's productions, but also by eliciting some of the patient's dreams and fantasies. The least defended area is the area of least resistance. The patient attempts to involve the

therapist in a sadomasochistic pattern, and the therapist must be aware of this and recognize that it is most important to avoid such participation. In short-term therapy, one cannot analyze this aspect of the problem; one might, however, in one sentence, in passing, refer to the problem. We have mentioned that Geleerd (1965, p. 122), remarked that “in order not to lose his parents’ love, the child adopts their repressions, denials, reaction formations, etc. Thus only by taking over a considerable part of his parents' neurotic ways can he join the human community. It is a paradox that the human being, in order to communicate with others, has to learn their faulty ways of dealing with conflicts.” This is one factor in the total problem that cannot be worked through in short-term therapy.

A second concern is the suggestibility trait in borderlines, which I believe to be a function of the instructions received from the authoritarian (controlling! parents to play the identification role so necessary to the parents' neurotic needs (Wolberg, A., 1960). Thus, *suggestibility* is one of the elements in the organization of the interlocking defensive system evoked in the family. Jackson’s thesis in “An Episode of Sleep-Walking” (1054) regarding suggestibility (a trait also noted by Freud in relation to masochism that Freud thought was a

characteristic in the positive transference) was that acting out has the quality of a *posthypnotic suggestion,* an important idea relative to the parents' obsessive insistence that the child act out a particular identification role. The parents' repetitiveness and their controlling and punitive behavior produces a conditioning effect similar to a posthypnotic suggestion, and acting out is a manifestation of this suggestive effect in view of the parents' sadomasochistic ways. One is especially mindful in this relation of what Lewis Wolberg (1978, pp. 13-33) has called the nonspecific effects in the therapeutic process since these are valuable aids in the therapeutic endeavor. The suggestibility trait can be helpful. However, this trait can be a stimulus for countertransference difficulties in the therapeutic process, particularly in short-term treatment. Suggestions for action that are necessary in the short-term process must be given in a way that will not represent a demand on the part of the therapist but will correspond with a rational wish on the part of the patient, a constructive wish for a particular kind of behavior. The particular focus in short-term treatment, then, must relate to a normal desire on the part of the patient. This desire provides the motivation for carrying out the task even though past experiences with parents may have

produced inhibitory responses and guilt movement. Past experience may have caused the child to inhibit and substitute an acting-out pattern, a manifestation of identification behavior, that I call the PT (pantomimic transference).

A third tenet in short-term treatment is that while the identification role is a way of maintaining a neurotic role, and is evident in the patient's productions and in his relations, we, however, *cannot* work it through in short term treatment. We can only be aware that in transference suggestibility and idealization of the therapist and appeasement are operative and that devaluation may occur too. One can give attention to this pattern only in passing. It is not a theme for real focus, for it cannot be worked through in a short period. An aspect of the pattern may be considered however, in relation to a practical problem, one that can be resolved.

A fourth corollary is that the destructiveness of the parent is evident in the interlocking defensive relationship. In this relationship there is a rejection of the child, as child, and the child is used as a projective object, and as an identification with the parents' parents; thus there is a need and a sadistic pleasure in controlling the child and

having him act out. The patient is a person who has felt rejected most of his life and cannot take “love” or kindly feelings from another without feeling great anxiety. Therefore, it is imperative that the therapist does not try to sympathize or give undue praise—even while recognizing forward moves.

Fifth, the denial mechanisms of the parents and their demand for the child to deny their behavior creates inhibitions in the self-actualizing behavior of the child; consequently, over time, revenge feelings arise in the child. These revenge feelings are the basis of the patient’s sadism, and his fears of his destructiveness. The guilt factor must be dealt with—not necessarily in regard to original figures but in relation to forward moves with respect to that small aspect of the total problem that is considered for the focus of the treatment.

A sixth factor is that the borderline patient’s anger and rage is partially controlled by “undoing” and depression. Anger, guilt, and undoing are functionally related. This fact is the reason for the many attempts made by the patient to overcome his inhibitions. The patient makes many false starts, so to speak, before he can carry through on certain forward moves.

Seventh, the child has been made to feel guilty in his efforts to extricate himself from the role that the parents need from him. He has been made to feel that his protests are an act of aggression against his parents. If he wishes to step out of the role and act'in a more rational and constructive or autonomous way, he is punished. There is no punishment for behavior that gives no anxiety to the parents so that there are areas where the patient is free to act. When the patient comes into therapy he is a guilt-ridden person, for he is asking for help to release him from his neurotic role, an act that was seen by parental objects and his superego (the S(IA)D)[20] aspect of the superego I as an aggression against them. They did all they could to counteract forward moves, and now the superego acts as the parental prohibition. If the patient is married, the spouse usually plays this prohibitory role too. One or two sentences regarding guilt are usually necessary in any given session. Anger can be explained as self-hatred in certain types of situations. Anger is mentioned as a response to guilt.

Eighth, in his family situation the patient has learned to deny certain aspects of reality, i.e., to ignore stimuli that provoke certain normal "responses and to inhibit certain of his normal impulses. This mechanism is apparent in treatment and can be commented on with

benefit. This must be done in common-sense terms using everyday language.

Ninth, the individual begins to fear his revenge feelings, he wishes to deny them. If interpretation of this mechanism is indicated, one uses a projective technique employing either the other or the therapist himself as the projective object for the deflection. Now he operates on two levels; he denies certain portions of reality, and at the same time he has an accurate perception of reality. These two levels are aspects of the “splitting” that has been noted and attributed to the ego. There is a repressed section of the patient’s mind and a conscious section operating simultaneously and effecting each other according to the degree of the patient’s anxieties. In short-term treatment we ignore many of the statements regarding the psychopathology and take note of the normal statements made by the patient, i.e., the reality or rational statements. We focus more on the reality constructs than on the productions that have to do with pathology. While we recognize the pathology, we interpret it only in relation to that aspect of the problem that we chose as a focus. Thus we must interpret only in the context of this focus.

Tenth, in the sadomasochistic situation at home the child learned not to trust the parent, realizing that he was unreliable and destructive. Thus he learned to fear authority as well as to distrust authority. This attitude can easily be transferred to the therapist, and for that reason in short-term therapy we speak only in clear everyday language making no ambiguous statements. We do not avoid the anger, but we do not try to analyze it— we only *show* how it can be a defense.

Eleventh, in view of the projective defenses, a projective technique is of importance in treatment (Wolberg, A., 1973, 1977). One must also have a concept of the kind of generalized treatment scheme to be followed with all patients and an understanding of how this scheme may be applied on a practical level within the confines of a segment of the problem. Thus, hopefully, the patient can work through his problems in the future when the therapist is not present, by applying what he has learned.

Twelfth, the principles of short-term therapy are the *first steps* in the longterm treatment process. We take a small aspect of the total problem and work it through with the patient hoping that the insights

will help the patient when his next anxiety occurs so that he will see the similarity in his current situation with the one that he worked through in his first experience. This first success is what helps the patient trust the therapist.

## Case Illustration—Mrs. C

I have no better example of a short-term case with a borderline patient than that of Mrs. C, about whom I wrote in the book edited by L. R. Wolberg (1965). Actually, in this case these were two trends that were followed, both having to do with the patient's fears of aggression. The "common-sense" interpretation of the problem was twofold: (1) you will not kill your husband or injure him if you leave the house to pursue some of your own interests, and (2) it is not a manifestation of anger or hate if you make realistic demands upon your husband even though he is ill with a heart condition. To summarize this case, Mrs. C was a 44-year-old woman, seen for a total of thirty sessions, once a week over a period of seven months. She had been married only 6 months at the time she applied to the clinic for treatment. Dissatisfied with what she termed her "incomplete sexual adjustment," she was seeking help at the suggestion of her husband who was in

psychotherapeutic treatment and who had become unhappy with the marriage. At the initial interview with the psychiatrist, she complained that she had never experienced “vaginal orgasm,” which turned out to mean no orgasm. Her first sexual experience occurred at the age of 30, and from that time until her marriage she had had five unsatisfactory sexual contacts, all with men younger than herself. She confessed feeling guilty over recurring thoughts during her marriage about her last boyfriend. She had no complaints other than her sexual dissatisfaction. She said, “I have anxiety about my husband’s cardiac condition and am coming to therapy primarily to do everything to make our marriage a success.”

The diagnosis made at the initial interview was “personality disorder with frigidity.” Asked about her preference regarding a therapist, she said that she wanted a female analyst about 30 years old. The doctor felt she would do well with short-term therapy since it was obvious the patient was not motivated to work out her basic personality problems; rather it appeared that she merely wanted to be relieved of certain symptoms. (It is important to note that I did not take her story about frigidity at face value, thus taking it as a focus for treatment. Rather I went on to discuss the problem in its broader

areas, finally discovering why she actually came to treatment and basing our work on what the common-sense factor was in relation to her *immediate situation.)*

> Mrs. C was born and raised in a small New England town. She was medium of stature, with graying sandy-colored hair. She wore a hearing aid, which was well concealed; her face was plain, and she used little makeup. Her attitude during the first interview was one of utmost cooperativeness though she seemed ingratiating. One had the feeling that she was going into this therapeutic situation as if she were tackling spring house cleaning—a necessary job to be done, "so why not pitch in and get the task over with." She was the youngest of four children, with two sisters, 5 and 10 years older than herself and a brother seven years older. She was one of a pair of twins, but both her twin and her mother died of an infectious disease when the patient was a year old. She described her father, a Protestant minister, in glowing terms: a "wonderful, kind man loved by the whole town." Her home, to her, was a cultural mecca in which music, art, and literature were enjoyed. She herself was an accomplished pianist. There was no further elaboration about her sisters and brother or her feelings toward them. Her father, she said, had remarried, and she described her stepmother as a "wonderful mother to the children and a wonderful wife to her husband." Her father and stepmother, she said, had died eight years ago, and the patient felt a great loss, particularly at the death of her father. She then focused on her

relationship with her husband, and it was decided that this was where she wanted the help.

Beginning the first interview with a long, circumstantial history of her masturbatory activities, she led up to her sexual relationship with her husband. She spoke with little apparent conscious guilt. Interspersed in this account were comments of thinly veiled hostility toward her husband, such as “I worry about his heart during intercourse.” “My husband thinks his penis is too small.” “My husband and I never discuss his dying.” She *outlined numerous complaints that her husband had about her that he said he hoped would be eliminated by treatment.* He objected, for example, to her twirling her hair, picking at her face, and monopolizing conversations. She expressed considerable concern over whether these habits could be eradicated, and she agreed with him that they must be annoying to live with. He had suggested that twirling her hair was connected with masturbation, and she wondered whether this was true; if so, would the therapist please get to the reason for it. She was delighted with the choice of “therapist” since she had wanted a woman to help her. She felt, she insisted, completely at ease. Throughout the interview, and at subsequent ones, she displayed an almost manic push of speech. She rambled rapidly so as to be almost irrelevant. This rapid speech combined with a happy, smiling, elated manner was suggestive of a serious personality problem. When the therapist asked her to describe her mood during the session, she replied, “I am sad that I met my wonderful husband too late.”

A brief summary of her husband’s problem described him as a warm attractive man of superior intelligence. He had a severe reality problem inasmuch as he had had two coronary occlusions with resulting anginal pains. In addition, he had reacted to his physical problem by refusing to expose himself to gainful work. His purpose in seeking treatment at a clinic was to discuss this problem with a trained person. He was assigned to a psychiatrist.

At the second session the patient brought in a series of dreams, all carefully written down together with her associations to them. (She knew this was the thing to do when one was in therapy.) One of her dreams was, “There was a house with an attic, a second-floor room, and a big attractive downstairs room. The landlord decided to shut off the second-floor room, and the only entrance to the attic was by an upright ladder from the large room below. He erected this ladder.” Her written associations were, “I immediately thought the second floor was my clitoris, and the downstairs room my vagina. The closing off of the main entrance and the erection of the ladder meant that I intend the clitoris reaction to come from the vagina rather than directly from outside. The focus of interest has become the vagina, or I want it to be so.” The therapist made no attempt to interpret the patient's dreams, merely accepted her associations with this statement: “Your associations seem to tell a story.”

Her association was to a vague feeling of being trapped,

particularly by marriage, but this was expressed in a completely disguised form by contrasting her feelings toward her husband with that of a friend who felt depressed after marriage. This trapped feeling was an important “here-and-now" feeling. It had to do with her current situation according to this association. Although she was willing to discuss sex ad nauseam, she only *alluded* to the depression and the trapped feeling. Her discussion of sex, while having some relevance, was, nevertheless, being used in the beginning as a defense.

In effect, the patient’s dreams served four major purposes: (1) they stimulated her childhood recollections (there were frequent references to childhood incidents), (2) they kept the therapist informed of the patient’s anxiety and how she was handling this, (3) they revealed the nature of the transference with the therapist, and (4) they served as a stimulus for *the patient’s associations, which were used in interpretations.* In other words, while dreams gave the therapist data, they were not probed or dealt with except to refer to the current relationship with her husband and to speak of her *feeling of being trapped.* It seemed apparent from the dreams that a borderline condition existed. The actual sexual relationship was discussed in common-sense language. When the patient said that her husband felt

his penis was too small, the therapist said, “He has self-devaluation tendencies. Is he afraid of sex, or of women?” This in a sense was a double interpretation or what I call a *projective interpretation*, for this same kind of feeling of inferiority was typical of her too as she soon told me.

> During the next session the patient began a pattern of alternately discussing her husband and her father. Whenever she mentioned a feeling or an attitude toward her husband, she would immediately compare it with attitudes toward her father. If she mentioned her father first, she would then compare these feelings with those toward her husband. Since hostility toward her husband was so thinly disguised, the therapist directed questions around this area. Why had she married her husband? “He thinks it’s so to take care of him. I wouldn’t want to leave him alone. I’d take care of him. I felt no one would take him away from me because he is so sick. I have given up trying for the best things. I couldn’t have an orgasm; I feared failure.”
>
> At the following session she began talking about what she called her “jealousy of attractive women,” relating her feeling of inadequacy to having had a pretty, older sister. Then she launched into feelings of dislike for her stepmother. She felt that her stepmother had been hypercritical in many of her dealings with the townspeople. Immediately thereafter she confessed that she did not

> believe that the therapist was as pretty as she had thought she was during the first interview. At this point she presented three dreams: (1) “A play was being rehearsed between a boy and a girl. The manager thinks it is immoral and separates them. I thought it was silly of him”; (2) “I went to the ladies' room and discovered it was the men’s room”; (3) “I am in bed and holding the landlady in my arms.” The first dream seemed to the therapist to be an ego acceptable resistance dream. This led her to ask the patient if she felt that therapy might cause difficulty between her husband and herself. It seemed that she was coming to therapy because her husband was pushing her due to his complaints. Did she believe that the therapist was critical of her behavior? The patient replied that she had actually felt that the therapist might come between her and her father. This was both the first and last transference reference that was mentioned during the entire treatment.

There are always transference reactions in short-term therapy, and the therapist must decide with the help of the patient’s dreams, fantasies, and other productions just what aspect should be interpreted. The interpretation should have a here-and-now emphasis with no particular reference to the past. If the patient mentions the past, there is no need to go deeply into the meaning of the past.

> During the next session Mrs. C brought in lists of complaints about her husband. She realized that she was

repulsed by his numerous illnesses. She spoke of fearing that she might choke him while he dozed under the influence of sleeping pills. Similarly, she verbalized feelings of hostility toward her father. She felt that her father had caused her sexual repressions because of his religious and puritanical values. He imposed his values upon all of the members of his household.

Following these five sessions the patient remained away from therapy for three weeks due to infectious mononucleosis. Upon her return, she continued to exhibit the same rapid speech, and in one session she presented a variety of subjects. She talked about her husband's having gotten a job and then having lost it and expressed the notion that he was testing her to see if she was worried or not. She presented two dreams. In the first, her husband had turned into a fly; in the second, half an orange, stuck on the wall, was attracting and sucking in flies. She then talked about her husband's resemblance to his degenerate half-brother, who had raped his own daughter. Realizing, as she talked, the irrationality of any such connection, she then read off a list of what she considered shameful acts that *she* had committed in her childhood. She finished with a discussion of her father's demands for compliance from everyone around him. *[Her discussion of her father's actions was an indication of implied demands for acting out on the part of her father and her own fears that she might act out in some perverse way using her husband as the projective object.]* The therapist mentioned the patient's *guilt feelings* and said that she might even have guilt about talking about

> her husband and her father as she was doing. It seemed, said the therapist, that she felt trapped by her father's values as she now felt trapped by her husband's illness. She was staying at home a great deal, isolating herself from her friends and giving up music and other interests.

In this and the following sessions in which there were always numerous areas of interpretation, the therapist emphasized only those problems involving her relationship with her husband—their social relationships as well as their sexual life.

> Mrs. C's problem consciously emerged as she expressed that *she felt deprived socially because her husband hesitated to leave his home.* It was obvious from her talk in the sessions that she felt trapped in the house with her husband and was deprived of the company of others—her social life was nil. Her husband's phobias kept *her* trapped as well as himself. She felt guilty if she wanted to leave the house without him. They were angry at each other in the kind of closeness they were forced to have. The patient's dreams, however, dealt with her sexual problem. They were interpreted to mean that she seemed to have some fears regarding her own sexual aggressiveness, as if she might destroy her husband in some way. She picked this up enthusiastically, recalling a fear that she might injure, if not break off, her husband's penis were she not to control herself in intercourse. At this point the major content and direction of therapy changed from expressions of hostility

toward her husband and father to one of talking about her intimate sexual feelings. This shift was ushered in by a discussion of a homosexual relationship she had had when she was 27 years old, which consisted of mutual masturbation with a woman with whom she had shared an apartment. She revealed this with much guilt, and the therapist responded with some educative material explaining the prevalence of certain kinds of masturbatory experiences, especially among girls and women who fear rejection by men.

The content of the next two months of therapy, eliminating circumstantial details, brought out many fearful obsessive thoughts. She spoke of having been frightened for years of being raped by men and of occasional thoughts that someone would put a hypodermic needle into her in the subway and cart her away to a white slave market. It was with some anxiety and guilt that she discussed her feelings of repulsion when her father kissed her on the mouth when she was a young woman. Treatment of these obsessive thoughts, which were also fantasies, consisted of discussing them as symptoms of a great fear of men sexually, and of her father in particular. Such fears, she was told, often preclude any real sexual relaxation and enjoyment. She confided her feelings of distaste for her husband's sexual advances. She then spoke for the first time of her notion that she might have injured herself through masturbation. She feared also that she might learn to be happy sexually without men. She had some nightmares, but the anxiety was not too intense as illustrated by these

> dreams: “I am supposed to shoot a gun at someone. A snowball comes out.” “My husband, a woman, and I live together. I see an auto crash over a bridge. Actually I expected to see the crash, but apparently there was none, and the occupants were unharmed.” "I fell off a cliff and nothing happened.”

These dreams seemed to indicate a greater control over her feelings and fears of violence. They also seemed to the therapist to be an indication that she might be less fearful of making certain kinds of realistic demands on her husband and that the therapist would support this kind of behavior—not her hostility but her realistic demands. The therapist made the following interpretation: to make realistic demands is not being hostile. Shortly after this she began to experience orgasms.

> In the session before her first orgasm she revealed a dread that she would urinate if she were to relax and enjoy intercourse. She recalled her disgust at her first discovery that men both urinate and have sex with the same organ. The following session she burst into the room saying, “I had three orgasms.” She then described the following dream, which was the only one she could remember during the interval between sessions: “There is a scene in the mountains with a church; the building hangs precariously on a cliff.” The rest of the discussion in the session was

> spent in describing the pleasure of her sexual accomplishment, the feeling of freedom which she now experienced, and the ability she had displayed in arguing with and expressing resentment openly toward her husband; this seemed to have released her in her feelings. She could see that her anger did not really injure her husband or herself. The therapist mentioned that she might now wish to become more mobile socially. If her husband did not care to go out, for example, perhaps she could go with a friend occasionally. It might be safe to leave her husband for an evening.

With the removal of the symptom of frigidity, the patient felt that the goals in treatment were accomplished, although her relationship with her husband was far from a good one. She continued, however, with the treatment for two more months. She focused on her attitude toward her husband, the therapist encouraging her to engage in her own cultural and social interests, art and music and social relations with other women.

> A slowing of speech was apparent, and her dreams seemed to indicate a further reduction of her habitual fears. The following dreams illustrate this: “I am in a railroad station, I went to the ladies room. There were five men there [this is the number of men with whom she had had sexual contact], I accepted them as having some right to be there.” The second dream was, “I am 15 and at home kissing

a boy. I felt that my stepmother would not disapprove." At this point she no longer assumed a protective role toward her husband; she began to make realistic demands of him. The effect of this change was that he did find a job. His severe anginal attacks greatly decreased. At the same time she no longer restricted her own activities by martyrizing herself for him. She began to take up her cultural interests again. She resumed attendance at concerts and the theatre, and went back to her piano playing, perfecting it to a point where she gave a recital.

Shortly before the termination of treatment she presented the following dream; "I am in a church with my father, I realize that I don't have the right handle to my umbrella, so I go into a new house where I find the right handle. Then I discover that I am not in church but in a political meeting, and that the man is not my father but my husband. I am very happy about the whole thing." During the last month of treatment the patient seemed to be handling her problems of daily living assertively. At her suggestion and with the agreement of the therapist, she felt that it would be a good time for her to stop coming to sessions and to try things on her own. A three-year followup via telephone showed the outcome to have been favorable.

In speculating what happened here it would appear that somehow—even though I happened to be older than her prerequisite for a younger woman therapist, I was able to establish a relationship

with the patient that was not too frightening, one in which she could talk about the situation without developing overwhelming anxiety and where she was accepted in spite of her aggression and perverse habits. She was thus able to take what the therapist said to her with a minimum of anxiety and could therefore focus on her symptom of frigidity and her wish to become free to follow some of her own interests and desires, even though these did not coincide with her husband's concerns. She felt less trapped by the marriage and thus had better feelings for her mate. She was not motivated originally for therapy; she came primarily because her husband was complaining about her habits. Her wish was to be relieved of the burden of guilt that she felt in having so much hostility toward her husband. As her guilt abated through talking, she was able to go on with the marriage. The therapist never suggested areas for her to explore, and never made interpretations that would force her to look deeper into her unconscious. Only those problems which she herself raised were discussed. In terms of what was accomplished, it seemed that she worked through to a manageable degree, by what might be called "conscious insight," her sexual disgust for and her hostility to her husband. She also appeared to have touched upon enough of her

oedipal conflict (insofar as she verbalized that her feelings for her father were interfering with her relations with men) to enable her to get along with her husband with some measure of relaxation.

The relationship between the therapist and the patient was kept on a positive level; transference was not permitted to build up to irrational proportions; the reality situation was focused on at all times; the content of the interviews was related to stress factors with which Mrs. C wished to deal. No attempts were made to open up facets that she herself had mentioned but that would require probing. The problems tackled were those she presented and could discuss openly. While no encouragement was given her to bring in dreams, she did this on her own, feeling that this was what was done in therapy, and her dreams were utilized as guidelines to conscious feelings. She was given common-sense interpretations with respect to certain aspects of the dreams. The negative transference was largely ignored except for the interpretation that touched upon the possible hostility that she feared the therapist might have toward her, based on a fear that the therapist might act like the stepmother. (This was actually a projective therapeutic technique for dealing with the patient's fear of her own hostility, using the stepmother and the therapist as the projective

objects.) The projective technique was organized around the possibility that the patient was identified with some of the hostile attitude of the stepmother and the controlling father. The patient’s sense of being controlled by the husband’s illness was reminiscent of her being controlled by the father and some of her rage toward the husband was transferential. The patient feared the therapist would be like the stepmother, but in the end the stepmother, according to the patient’s dreams, did not interfere with her sexual relations with her husband, an interference that she projected from the attitudes she felt her father and her stepmother displayed in actual life. We may theorize that the projective therapeutic technique touched upon enough of her repressed feelings and thoughts so that she was able to resolve some of the transference feelings by differentiating the therapist from the father and the stepmother.

The therapist was careful not to become too deeply involved with the patient's sexual material, which was in a sense being used by the patient at that time as a defense. The material was meaningful, however, and revealed much about the patient’s sexual anxieties, her fears of being rejected sexually, her anxieties about her sex role, her need for assurance, her feeling of being trapped and injured by a man,

her feeling that she may have injured her self, and so on. The interpretations were made around the general theme of her feelings of being trapped and her fears of her own aggression. When she was able to get angry at her husband because of his nagging and express her anger rather than hold it in, she felt released.

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## Notes

19 Bernard Riess, then Director of Research, at the Postgraduate Center for Mental Health in New York City, in 1976, conducted a study which indicated that patients treated at the Centers clinic were able to advance themselves economically after 32 or so sessions of treatment. This advance was considerably higher than the average economic advance of individuals in the general society. In the clinic's caseload there were many borderline patients.

20 S = superego; IA = identification with the aggressor; D = feeling of denigration and depression.