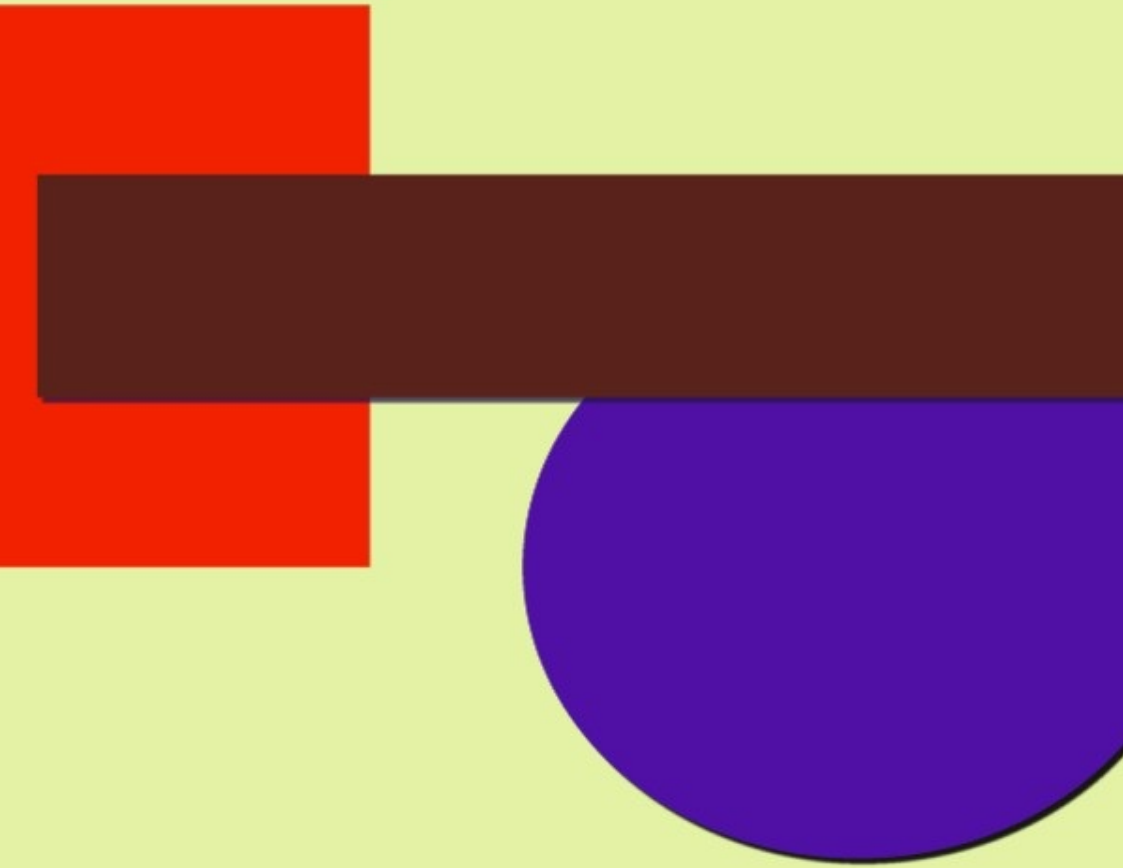
EARLY PAPERS

Present Day Implications



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Early Papers:

Present-Day Implications

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e-Book 2017 International Psychotherapy Institute

From *Psychoanalytic Psychotherapy of the Borderline Patient* by Arlene Robbins Wolberg

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Early Papers: Present-Day Implications

The psychiatric literature reveals that the borderline patient was a focus of interest as far back as 1884 and 1890. The word *borderline*, however, was not used, although from descriptions, patients that we think of as borderline today seem to have been included in case studies. This chapter will set forth briefly the views of some of these early writers and examine them in reference to current theories.

Charles H. Hughes and Irving C. Rosse

In his book co-authored with Werble, Grinker (1977) refers to two papers in the bibliography, one written by Charles H. Hughes of St. Louis, lecturer on nervous disease, St. Louis Medical College, and another by Irving C. Rosse, of Washington, D.C., professor of nervous disease at Georgetown University. In reading these papers, I found cases that might now be classified as *borderline.* Hughes wrote of patients whom he had seen in 1878 and 1882 who had obsessions (almost to the point of delusions). Morbid ideas, he said, dominate the mind of a person who may eventually have a psychotic attack, but in some cases this could be avoided by certain interventions. One man had developed a symptom of not being willing to eat potatoes after he

observed workers in the field spraying potatoes with Paris green, an insecticide. This obsession generalized to “all things green.” When he was a child, someone had fired a toy pistol in the patient’s ear at the same time that the patient had seen the workmen spraying. The patient improved slightly, over time. The other patient whom Hughes described, developed symptoms “on the left side” after having been struck a violent blow on the head with a cane. He had a rapid pulse, constant headache, and a green spot before his eyes that gradually widened until he could see nothing else; also he had numbness, impaired vision, and a roaring in his head. All symptoms disappeared after a few months of treatment, which consisted of “cephalic galvanization” (the rubbing of electric sparks on the skin) and the taking of “bromides and arsenic with occasional courses of quinia.” These men were considered to be cases of “partial or limited insanities.” According to their description, we might now classify them in the borderline category if illnesses, with an emphasis on obsessive and hysterical symptoms.

Rosse (1890) wrote of “borderland insanity” cases, i.e., individuals whose minds were “trembling in the balance between reason and madness, not so sane as to be able to control themselves, nor yet so insane as to require restraint or seclusion.”

What is interesting about these reports is that the patients received short term treatment, and symptom relief was attained in a considerable

number of instances. While the symptoms in some situations did recur after a time, in most instances they did not come back. The question we may ask is, Why for some did relief persist? Was it tension alleviation? Certainly that helped. These early therapists used suggestions freely. For example one patient was advised to take a sea journey, which seems to have given him freedom from tension. In another case the individual was a "work-a-holic," and telling him to take a trip to Europe was liberating for him. This may have reduced the guilt that was driving him. The primary symptom for these patients seemed to be one of an obsessional type with hysterical tendencies. Apparently, medications such as bromides were used in those days to relieve worry and anxiety. In each instance the individuals had motivation to get better. They realized something was wrong; most feared insanity; all were amenable to suggestion. Even one man with paranoid trends had insight of a certain kind.

The borderlines whom we see today are not so well organized around one symptom as these patients seemed to have been. Today we see the characteristic *shifting of defense* that was noted by Hoch and Polatin (1949) in their "pseudoneurotic schizophrenics." The same kind of speculation, however, goes on today, where we see symptoms disappear as in Hughes and Rosse's day. What was it that produced the symptom relief? We tend to credit these short-term techniques to a kind of behavioral modification or to a certain degree of psychoanalytic understanding. Some analysts feel the "cure"

is due to a partial resolution of the oedipal situation and the idea that the patient "identifies" with the "healthy" analyst rather than the "unhealthy" parent. The fact is that while many so-called obsessional symptoms are an overlay of a basic schizophrenic problem, the symptom can apparently be overcome in the majority of cases with short-term procedures.

"Cure" or relief of symptoms is due certainly to what Alexander and French (1946) called a "corrective emotional experience." Usually this means a nonpunitive experience with the therapist, who does not attempt to control the patient's behavior. The treatment person is thus a different type of individual from the parents—one who is more flexible, less demanding, and not demeaning. Experience today with such patients shows that they respond to brief methods using behavior techniques, hypnosis, and relaxation exercises. The best results occur, however, when a dynamic theory is used as a basis for the employment of these measures with the recognition that transference and certain kinds of resistance must be interpreted in common-sense terms within the therapeutic relationship. Interpretation is applied to the patient's here-and-now concerns, in the interpersonal context of his daily life where he understands the problem to be operative.

One patient reported by Rosse (1890) was a prominent, middle-age businessman who had suffered from "obstinate insomnia" for many years. During that time he had developed a "bromide habit." He expressed

hypochondriacal ideas and morbid fear. He was impotent and had a suicidal impulse. He "complained of general languor and debility; of a clawing pain within the head; of inability to concentrate his thoughts; of loss of will power; and a fear of insanity." He took enormous doses of bromides daily, but he had managed, over time, to decrease the dosage slightly. Rosse was about to give up on this patient when a colleague told him that he had treated a similar case by "prescribing a solution of chloride of sodium," the dose of which is gradually increased, "the bromide at the same time being gradually decreased until a few minims is reached, when the patient breaks off the habit on being told that he is taking nothing but common table salt." This plan succeeded until, during Rosse's summer vacation, the patient accidentally learned from the druggist what he was taking. He immediately canceled the prescription, and his symptom reappeared. On his return from vacation, Rosse "in a fit of desperation" directed the patient to eat large quantities of grapes, "the object of which was explained to him," and within a week there was a "salutary change." The patient's "psychical depression" was reduced, and the craving for the bromides was nearly gone. Soon after, the habit was broken. The patient was able to sleep; he regained his virility; and he was rid of his morbid impulses. Rosse described other disturbed individuals who recovered their stability with a type of short-term directive therapy and placebo.

Montague D. Eder

In 1914 Montague D. Eder, in England, wrote a paper with the word *borderland* in the title and *borderline* in the text. About this time Freudian ideas were being studied, and Eder recommended the use of such concepts in understanding the "dynamics" in the diagnosis and treatment of psychiatric cases. Freud's paper "On Narcissism" (1914) had appeared in which he referred to certain patients as a "third type of paraphrenia" (Freud, S.E. 14:86-87; Wolberg, A., 1968). Such a patient did not withdraw from objects completely; or if he did so, "he reestablished himself with the object again . . . after the manner of a hysteric in dementia praecox or paraphrenia proper, or an obsessional neurosis (in paranoia)." In this passage Freud recognized the type of patient who has withdrawal tendencies yet remains related to objects and who has paranoid trends and symptoms that at times resemble hysterical complaints and at other times obsessional traits.[1] Eder in his paper did not specify which dynamic concepts he thought were especially important. Freud emphasized in his group of patients the withdrawal into fantasy yet the maintenance of a relationship with objects. This led him eventually to consider "character traits" as opposed to "neurotic symptoms" (Freud, S.E., 1915, 1917). The types Freud delineated in his essays had what we would call today passive-aggressive characterological patterns. According to his descriptions, they had sadomasochistic modes of relating, but when he wrote of sadomasochism in the essay "A Child Is Being Beaten" (1919), he pointed out that this was an oedipal problem. The narcissistic neuroses were seen as

preoedipal—borderline schizophrenia being one of those preoedipal disorders. The essay on narcissism was meant to describe the development of the ego in the early phase of life when difficulties began for these patients.

W.A. Jones

W. A. Jones described a passive-aggressive personality in a paper published in 1918 in *Lancet.* The writer had no knowledge of psychoanalytic concepts, but he noted certain character traits in these patients. He stressed particularly their "neurasthenic" symptoms and remarked that one must surely differentiate between those who do indeed have a physical condition and those who do not because the former could often be cured immediately by medical means; the others he felt pessimistic about, showing a most unusual kind of negative attitude toward such patients. He called those who did not have a physical condition "vampires" who are enslaving, captivating, and destroying. Thus he saw the acting-out symptom of these patients with the concomitant aggression.

The paper by Jones demonstrates the extreme countertransference problems that a naive therapist may have in relating to the more difficult patients. Of these "impossible ones," Jones wrote of the woman with "wiles and witcheries", of patients who are "intellectual but not necessarily intelligent (those who are "bright but act stupid"), the "sweet babylike

vampire," the "selfish vampire," and the "ugly vampire" who rules with a rod of iron. Of the vampires, he said, "These people can and do cause many heartrending situations and are able to upset, not only individuals, but communities" (the term "acting out" had not become popular at this time). "There is unfortunately very little to do for these people, as killing them is still considered a crime. . . . They look ugly, and they are ugly in mind and body, and yet there is no help for us other than complete annihilation." The reaction to the patient's aggression and hostility would render Jones useless as a therapist, I would think. Jones could see the hostility in these patients, but he did not recognize their masochistic traits.

There is no doubt that borderlines and certain other types of "passive-aggressive personality" do create disgust and dismay in people and desperateness when they have interpersonal contact with them. There is in the Jones paper, however, a lack of distinction between borderline patients and paranoid people. The latter do not have obvious delusions and hallucinations but are, in many and varied ways, acting out their destructive impulses and concealing their paranoid pathology by being purists, such as people who fight constantly against the sins of others. Jones did see, without understanding the dynamics, the sadomasochistic person with hypochondriacal symptoms who forces others to care for him and who makes others feel guilty because of all the disasters that the patient has been through, due primarily to his own self-destructive behavior. It is to be noted

that the "borderland" patients whose acting-out qualities were not comprehended by these early therapists often had suicidal ideas. Those who were obviously acting out impressed these doctors as hostile, destructive, and ugly. In the current literature there is a paper by Eigen (1977) relevant to the reactions therapists may have to such patients. One might make the point that it is not only the therapist who may feel disgust for these patients; the individuals themselves often feel self-disgust, but they defend against this by trying to make others feel guilty, often projecting blame onto people outside the family who have had no real role in the development of their problems.

L. Pierce Clark

L. Pierce Clark began discussing the *borderland* case, which he also called the *borderline,* in 1919. His writings show an extraordinary astuteness in working with these patients, and he delineated tactics that we are rediscovering today. Even though his work was influenced by Freud's theory of narcissism and is tinged with many of the misconceptions of present-day psychoanalytic thinking, some of his suggestions for treatment are worth considering. It is obvious from his writings that Clark considered the borderline patient to be passive-aggressive and sadomasochistic. He spoke of the necessity of going "carefully over the conscious and foreconscious settings of the patient's difficulties, especially those which seemed to act as precipitative causes . . . not until then did I take up a strictly psychoanalytic

approach." He found the dream productions of such patients "for the most part engrossed in quite adult settings," and they were "not so latently obviously sexual" as in cases of the neuroses. He considered it necessary in the interpretation of dreams to ask the patient for "memories of actual experiences . . . a more or less common-sense reformulation of their life problems" being essential. The analyst himself uses analytic insights but does not interpret these to the patient in the regular analytic way except in common-sense "dynamic terms." These ideas may not seem so revolutionary today. However, at the time, coming from a psychoanalyst, they were most unorthodox, and they are particularly relevant in treating character problems of the passive-aggressive type—the typical characterological makeup of the borderline patient. Whitehorn and Betz (1960) have documented Clark's approach to borderline patients. Shows and Carson (1965) duplicated their experiments.

The unorthodoxy of Clark's ideas can be seen when we realize that the developmental psychosexual concept in relation to the instinct theory was in vogue in his time and the "unconscious" was considered more important than the "conscious." Student analysts were being told not to let the patient talk about "reality" or what was going on in the actual life situation. The analysis centered about the "id derivatives," early Freudian ideas having given way to the topological concept, infantile sexuality, and the defenses against the instincts of sexuality and aggression. The notion of a constitutional factor and

"a weak ego" in the more distressed patients was also very-important in this period as was the concept of "defective development." Freud, however, did speak of "ego modification," a concept that seems more adequate than that of "ego defect" since the word *modification* connotes *a certain kind of ego organization.* But the word *ego* itself is a polygot melange since it includes almost all that the individual says, thinks, and does. Its breadth, consequently, renders it useless as a scientific tool. (If we are more parsimonious in theory, and less global, we shall do ourselves a great service.)

Clark's idea in treating his patients was that psychoanalytic knowledge is important in understanding how the patient behaves and that therapists should use this knowledge to explain the patient's here-and-now problems, anxieties, and feelings. But the interpretive language, he emphasized, should consist of everyday words and concepts; thus the type of interpretation employed in traditional psychoanalysis should be avoided. Clark thought that the therapist should not try to pierce the patient's protective armor (his defenses). He should make no demands upon the patient and have a noncritical attitude, a kind of "casual wondering why may sometimes be necessary."

Like Kohut (1971) today, Clark felt that the analytic situation with the borderline is similar to an early mother-child relationship of the preoedipal type. The goal in the beginning, said Clark, was to help the patient work

through his preoedipal problem so that he could, through identification with the analyst—"the perfect mother"—attain a higher level of ego organization. The initial relationship with the analyst is on a "narcissistic level," and "primary identification" is the aim in the beginning. In this respect, Clark's orthodoxy was manifest, and he was following a psychoanalytic ego concept that many analysts still use. Actually, in analysis we must *resolve the patient's identifications with his parents and his tendency to identify with the therapist, an activity that is a denigration of his own propensities and qualities.* Freud recommended the dissolution of the identification as an aim in treatment, but at the same time, in his ego psychology, he introduced the concept of identification as a normal motif in "ego development." Most analysts then assumed that due to the patient's "defects" an identification with the analyst (the good mother as opposed to the bad parent) was the nub of the curative process.

According to Clark, the analyst, like an ideal mother, must be "a complete ally to the patient's efforts to get well. . . . An ideal mother is a noncritical mother, a staunch friend." While the analyst does not accept the patient's neurotic attitude toward reality (the patient fears reality and feels the environment is inimical), he is, nevertheless, not critical or punitive. He does not question the patient's attitudes, but he may generalize about some of the problems the patient says that he has. For example, he may question the patient about why the patient believes certain people (with tendencies

similar to those of the patient) act the way they do. Both the analyst and the patient work together to investigate "the critical attitudes of the environment." (This is a projective technique.)

The analyst may have to do more of the talking in the beginning, said Clark, but the patient will understand through this that the process is a "talking treatment" covering a wide range of problems. There is no interpretation, at first, of the oedipal or preoedipal problems of the patient; rather, the concern is *people in general and the way that the environment affects people.*[2]

What Clark was suggesting can be said to be an *interpersonal or group principle.* Discuss what is happening in the patient's here-and-now situations with others—his interactions and methods of relating. Clark advocated taking into account the patient's social or group contacts as the patient's neurosis was acted out in interpersonal encounters.

Clark thus proposed that the analyst have a noncritical attitude full of enthusiastic support for "healthy attempts" as expressed in social situations so that the patient begins to feel that it is an "easy process that makes him get well."

The similarities between Clark's suggestions and the findings of Whitehorn and Betz (1960) can be seen in a report by Betz. In a series of

studies focused on resident psychiatrists and their schizophrenic patients, Betz (1962) sought similarities and contrasts among the doctors with respect to styles of clinical transactions as related to personal characteristics. Comparisons were made to reveal any differential effects on patient outcome. The research indicated that some therapists consistently had high success rates with schizophrenic patients and others did not. In one study the five top-ranking doctors (designated *A* doctors) were compared with the seven low-ranking doctors (designated *B* doctors). Thesis had an average success rate of 75 percent with their 48 patients, while the *Bs* had only 27 percent with their 52 patients. A detailed analysis of the individual case records revealed differences in clinical style between the *A* and *B* doctors. The *A* group more frequently *grasped the personal meaning of the patient's behavior beyond mere clinical description:* they more frequently aimed at *modification of adjustment patterns and constructive use of assets* rather than merely symptom decrease or correction of faulty "mechanisms." They *set realistic limits in their goals in therapy;* they *avoided passive permissiveness;* their *interpretations of behavior were never given in an instructional manner.* The study was cross-validated on an independent sample of 18 residents and 109 schizophrenic patients.

The symptomatology, the Betz study revealed, became meaningful when it was recognized that the patients manifested a special orientation toward "authority as external and imposed" with feelings of suspicion and distrust

(fear and hate) toward the self and others.

The findings of Whitehorn and Betz concerning *A* and *B* doctors implied a sadomasochistic problem in schizophrenia with projective defenses. One finds this also in the borderline patient. The patient, they avowed, does not act from "inner leads," but at the same time he is wary of leadership initiated by others. In studying borderline patients, however, we may say that the patient does act from "inner leads," but he projects and often denies his inner feelings ("internalizations" of his problems) that are defended against by *repression* and *denial.* He sometimes acts as if his identifications are outside himself. The defense is against thoughts and feelings that were initiated by experience with parents, and the "inner problem" is that of the *conflict over the identification with parents*, now represented in the *fantasies,* which are, in fact, *identification fantasies.* In treatment when projection is operative in the borderline patient, one should not suggest ideas in the sense that Freud (1937) proposed in his essay on reconstructions in analysis, but one should use preconscious material from the patient's productions to outline the patient's everyday problems and conflicts in *common-sense terms.* The projected material should be employed by using *the projective therapeutic technique in interpretation* (Wolberg, A., 1952, 1973), that is, using the "other" in the relationship the patient describes, since in projection the material is too highly defended by denial and repression to make direct explanations. The rationale for this kind of interpretation is that the patient's projection is

actually a *projected fantasy depicting his identification,* and he has indicated that he wishes to talk about this problem, albeit denying this at the same time. The most extreme forms of the projected identification fantasy are the delusions and hallucinations seen in schizophrenia. The borderline patient has a loosely defined delusional system that is not solidified and rigidly organized as in schizophrenia, thus it is not a motivating factor in the patient's everyday existence (Wolberg, A., 1952).

The projective orientation is a formidable obstacle to the therapist who in treatment is striving for a "trusting relationship." The sadomasochistic personality is oppositional. A trusting relationship is difficult to establish, as important as it is in the therapeutic involvement.

"Insights" about "morbid pathology," Clark pointed out, are not essential in the first phase of treatment and do not help to cement a trusting relationship. This is because the patient, in the beginning, treats such interpretations as an assault. Betz said that common-sense interpretation "brings about relaxation of the barrier between the patient and therapist." She reported that "when this barrier is lifted," the symptom of "clinical schizophrenia" seems to disappear. (This would suggest that "clinical schizophrenia" is a *defense against anxiety* and that as the anxiety lessens in the establishment of the kind of relationship where the patient feels *accepted and understood,* his fears and feelings of "danger" are reduced and he can

relax his projective/delusional defense.)

Clark's proposal of a noncritical attitude and enthusiasm for "healthy attempts" is similar to Kohut's "mirroring" to give the patient self-assurance, to correct his denigrated self-image. Although this may not be solely a "mothering response," and one would not recommend that the analyst be "supportive" in the appeasing sense, encouragement for "normal" or "rational" behavior is an important element in any interpersonal process including that between patient and therapist. For one person to take note of the contributions that the other makes to positive constructive thinking and acting is one of the marks of a "normal" relationship. "Positive feedback" is another way of looking at this process. This principle has been considered in psychoanalytic literature to be an aspect of an identification process where the patient takes the analyst as an ideal and thus makes his first step toward "object constancy," that is, a separation of self from object and a primary move toward the formation of a superego. The theory today, according to many psychoanalysts, is that the borderline patient has not moved in this direction in his life with the members of his family, so he must accomplish the task in therapy.

It is true that the analytic situation evokes a new kind of intimate experience due to the differences between the analyst (therapist) and the patient's parents. The analyst's involvement with the patient's positive

contribution (in effect agreeing with him and his constructive ideas), however, is different from the patient's identifying with the analyst's ideas since identification means thinking and acting like another person. (This happened with his parents.) When we agree with a patient's idea, we simply see the idea as reasonable and commendable. It is for the patient to act upon his own ideas if he is to change his behavior. The analyst in this kind of agreement does not act like the patient, and the patient does not act like the analyst; there is a consensus of opinion, a group dynamic that eventually leads to action and change in a particular group member, the patient. This group dynamic occurs in groups of two (the so-called one-to-one situation) as well as in groups of three or more. The parents gave positive signs when the child identified with their neurotic behavior. The analyst agrees when the patient expresses constructive notions.

With the borderline patient there is one reservation in the beginning phase of treatment: supporting too avidly his positive ideas may be too anxiety provoking due to the patient's fears of change and his tendency to denigrate his own constructive thoughts. A move toward a different autonomy away from his sadomasochistic life pattern is excessively guilt provoking. (The sadomasochistic life pattern is a result of his identification with the neurotic ways of his parents, as we shall discuss later.) The use of a projective therapeutic technique is helpful in relation to this problem. Thus the analyst may use himself as a projective instrument for the patient's

positive wishes and potential moves. Although I have formerly described this technique (see Wolberg, A., 1952) as “positive ego construction,” I see it now as a means of counteracting the patient’s masochism. The analyst should try to take the responsibility for the patient’s positive ideas: “I see that you might like to take some courses at the university, to enhance your interest in sociology, but you hesitate to do so. It seems like a good idea and I would advise it. But first we should try to understand your anxieties about it, I might almost say guilt, because you look guilty and fearful when you talk to me about it.” Another way of thinking about the guilt problem in relation to positive moves is that the analyst, as Clark phrased it, must help the patient reduce the effects of his “punitive superego”; that is to say, in this particular way we help to correct the devaluated self-image, which is a function of the patient’s masochism. Eventually we show how the patient has “internalized” (identified with) the controlling or restricting attitudes of the parents, thus creating inhibitions and a condition of being boxed in. The technique is used in relation to forward moves that the patient might have made himself, activity that he would have liked to engage in as he was growing up had it not been that such rational behavior caused anxiety for the parents and they forced him, due to their anxieties, to inhibit these “healthy attempts.” As Clark saw it, we enable the patient to ’’identify” with the “analyst-mother” and to feel that the analyst is a friend. The “ego ideal” can then take form out of this “talking relationship.” The analyst is accepted as an “object of identification.”

The identification with parents evoked neurotic behavior while the identification with the analyst would produce normal behavior.

The concept of the "ego ideal" was considered to be extremely important in psychoanalytic circles when Freud presented it (1914) in the paper on narcissism, in which he also mentioned "ego libido" and "object libido." This was one of Freud's first metapsychological attempts to discuss the effects of interpersonal relations in terms of "internalization." What was thought to be so important was that this was a kind of forerunner of the idea of the "super ego" (this idea had been touched upon in the early concept of the "censor"). Actually, Freud had for several years been considering group process and its effect on the ego. The problem of understanding mental functioning and mental structure and the dynamic influence of the environment upon the individual in relation to ego functions was the core of the matter. How to conceptualize "systems of the mind" as well as "functions of the ego" and "internalized interpersonal relationship" were matters that Freud had been pondering over the years. The development of an ego ideal obviously depended upon group dynamics, and it provided a connecting link between ego and superego and between the ego and the object. While the ego ideal was a manifestation of group process, Freud regarded the organization of the ego idea as the instinct seeking an object in the service of development rather than the idealization being the function of an interaction between two behaving objects.

Today we have Kohut, who believes that the “ego ideal” is the “internalization” of the “idealizing self-object,” and this provides the basis for the formation of the “cohesive self.” (We shall discuss the self-object later.) Idealizing is thus a necessary step in the formation of identification and the development of the ego and the superego. The way Freud talked about his own father, whom he obviously idealized, may be one clue to his insistence that idealization must precede the organization of a superego. Freud thought that idealization occurred with respect to people that the individual either loved or feared. (One can see that in idealizing fear, hate and envy are the main emotions so that it is an appeasing or masochistic kind of mechanism, actually a defense rather than a developmental phenomenon.) Kohut (1971, 1977) says that as a first step the infant “internalizes" the functions that the mother performs. This is called “transmuting internalization” and is the foundation of “ego structure.”

The concept that the analyst must act as a female parent and repeat the mothering responses in a different way from the original mother so that the individual can make up the “lacunae” or “defects” in his ego and superego is open to criticism. It is a theory used by many current writers on the treatment of the borderline. The theory came from Freud, by implication, and Clark used the idea as Kohut does today. But Freud admonished, in spite of his earlier theoretical formulations, against the analyst’s thinking of himself as a model or ideal when he wrote: “However much the analyst may be tempted to

become a teacher, model and ideal for other people and to create men in his own image, he should not forget that it is not his task in the analytic relationship, and indeed he will be disloyal to his task if he allows himself to be led by his inclinations. *If he does, he will only be repeating a mistake of the parents who crushed their [child's] independence by their influence and he will only be replacing the patient's earlier dependence by a new one"* (Freud, S.E., 1938, present author's italics). Neurotically, this is precisely the kind of role that the patient tries to establish. The therapist, however, should not fall into this trap. A few paragraphs later in the same essay Freud says, "The therapeutic successes that occurred under the sway of the positive transference are open to suspicion of being of a suggestive nature." (I would think of the positive transference as masochistic or appeasing in nature as Freud himself had suggested earlier.)

"Wanting to be like the parent" may simply be the compulsive need to succumb to suggestion, a masochistic trait in the patient that has been conditioned in him by the parents' authoritative, punitive, and controlling attitudes, brought about by their own anxieties. This is the source of the "punitive superego," a masochistic need in the case of the borderline patient. In the beginning of treatment, however, the sadomasochistic stance is the only way the patient has of establishing a relationship that can be used to advantage. He knows only sadomasochistic modes of relating. The masochism must be interpreted to the patient at appropriate times, in everyday language;

it is related not only to the need to receive sadistic treatment (i.e., to be beaten, humiliated or degraded), but it is also a function of the guilt the patient has in stepping out of his sadomasochistic role into a more constructive use of himself. The patient feels guilty when he seeks psychotherapy, and whenever he improves, he also develops guilt and anxiety. Clark certainly recognized the sadomasochistic pattern, but he had a simplistic idea concerning these dynamics.

It is much more acceptable to the borderline patient in the beginning of treatment to discuss (1) guilt when he seeks psychotherapy and (2) anxiety in relation to some of his normal impulses than to probe his denigrating attitudes and the need to be injured that are associated with the sadistic fantasies that the patient has and often acts out. It takes a long time before the patient will discuss sadism in a meaningful way.

Clark wrote that the analyst must realize initially that the "harsh superego of the narcissist" must be dealt with. The resistance is amplified by severe repressions and "dependence on parental attitudes," the patient's entire personality having been inhibited in its chance for free development. Apparently Clark saw the influence of family members as an important aspect of the patient's problem. He assumed that the patient had a superego but that he would have to develop a new ego ideal in the course of treatment and modify his existent superego. Many analysts today contend that the

borderline patient has neither an ego ideal nor an identification system and, therefore, has to develop these. Others say that he has a superego but that he must discard what he has and develop a new one in his relation with the therapist. Clark said that the patient's "inability to maintain a real aggressiveness constantly allows the superego to take the drive of the destructive impulses and to use their violence in further punishing restrictions against the ego." A reduction of the effects of this "punitive superego" must be attained. (This, I believe, is simply another way of describing the patient's sadomasochistic pattern, particularly the masochism. This was imposed on the child by the parents due to their own anxieties and neurotic problems and their unconscious insistence on identification.)

Although Clark did not conceptualize the problem as I do, he, nevertheless, felt that the sadomasochistic pattern had to be taken into account early in the analysis. I believe that we must understand the dynamics of masochism as a function of the "punitive superego" and its relation to depression as a damper on aggression, realizing that the masochism and depression must be reduced first before a meaningful working through of the sadism can begin. The session with James Weber (see Chapter 11), a young psychologist, the son of a physician, illustrates the kind of sadomasochistic pattern that is established, in transference, not only with the analyst but with others as well. When James talks about his girlfriend, the teasing quality in his relationship is typical of borderline patients. This quality has been attributed

to the oedipal situation, which is obvious in this session, but it is also a characteristic, I believe, that has its origin in a preoedipal phase where the controlling parent has the child in a bind. James felt "bottled up" and "in a vise." His father was a "nervous tyrant," a compulsive person who had to have his own way about everything. He was easily irritated if James, an only child, or his mother "stepped out of line"—that meant doing something that would irritate the father who was very easily upset. The mother would plead with James "to be good" because if he weren't the father would "take it out" on her. Being good meant, for example, washing the car but doing that in exactly the precise way that the father wanted and not swerving in any way from the explicit directions the father gave. The father would "go to pieces" if his instructions were not followed to the letter. These rules were to be observed not only when James was a small child of 2 years but also when he was older —all through his teens and even when he was in graduate school. In analysis James revealed fantasies of being a wealthy man who could wield power over a country. He could actually act out his hostility only by withdrawing, teasing, and pitting one person against another. In one session with me he used the example of Kleinian theory to tease because he knew that I did not support such a theory. He liked to pit one teacher against another. Originally, James had wanted to be a physician, but he had flunked out of medical schools three times, and not because he lacked a brilliant mind.

The "punitive superego" (identification with the aggressor) supports the

sadism that is in part turned inward, a consequence of guilt over the hostility and revenge feelings that the patient has toward the parents, part of which he displaces toward others. The conflict is over the parents' controlling tendencies and their consequent inhibition of certain of the child's "normal" impulses, inhibitions that are "internalized" by the patient. In other words, the patient learns to perpetuate the inhibitions as a result of his identification with the parents, and this is the source of the operation of the "punitive superego" that keeps the patient in a trap. Frustration evokes aggression. Certain of the child's "normal" impulses originally created guilt and anxiety in the parents, and now, through identification, guilt and anxiety are mobilized in the child, who eventually becomes the patient. On the other hand, no inhibitions shadow those areas of behavior that were not considered dangerous or did not arouse concern or anxieties in the parents. Certain types of aggression are encouraged, for example.

The permitted aggressions of the patient are initiated by signals the parents give through their verbalization and their projective defenses, which enjoin the child to act out the parent's aggressive needs in some form or another. Szurek and Johnson (1952, 1954) and their colleagues found this kind of dynamic to be the source of the acting-out patterns of delinquents (both in sexual and nonsexual forms of delinquency). In my opinion this is the dynamic in all acting-out patterns—whether they be delinquent patterns in the judiciary sense of the word or destructive kinds of behavior in any form,

self-destructive or destructive to others, sexual or nonsexual.

While "identification" and the development of an "ego ideal" do not describe all that is actually taking place in the therapy between the analyst and the patient in the first phase of treatment (other activities such as problem solving do take place), there comes a time in this early stage (which with borderline patients can last anywhere from one to three years) where the patient, as Clark said, begins to feel understood, and he enters into a more cooperative relationship with the analyst. Obviously this occurs as a result of the common-sense delineation of those aspects of the patient's problem about which he can tolerate disclosure without intense anxiety and concerning which he can take positive steps to correct. In the beginning the positive moves are minimal and goals are limited. The patient recognizes that the analyst understands his self-defeating patterns and his anxieties and that the analyst does not participate with him in his neurotic aims. The use of generalizing and the projective technique will allow the patient to select those areas of the problem that he can bear to discuss. The relationship then becomes one that the patient feels is special and into which he can enter more freely. Although the relationship is still narcissistic, according to Clark (in my opinion, sadomasochistic), the patient's participation in the analytic situation at this point involves more of "secondary narcissism." The patient has begun to "give something" into the analytic relationship. The analyst is still "maternal and protective," but he has now a leverage with which to work

since the attitude of the patient is more favorably inclined. Kohut (1971, 1977) believes that in this process the analyst, acting as a mother, provides the milieu in which missing ego functions may be produced. “Gaps” are filled, and defects in the “self” are overcome. The mother “mirrors” and “praises” and “agrees.” She gives the child a positive conception of self. Is it not possible that the action or behavior stimulated by the patient’s positive or constructive ideas are what give him a feeling of coping and managing, and it is this that allows the patient to develop a feeling of self-confidence? The analyst merely encourages the patient to behave in the way that the patient feels might be important, since he agrees with the patient’s constructive ideas.

Clark in 1919 recommended “in the talking” it is possible to elicit a more and more elaborate description of incidents. The therapist (analyst) should also inquire into some of the patient’s “subjective feelings.” The material should be discussed in carefully phrased questions. In my paper in 1952 I expanded upon this. In asking questions and elaborating on situations, the therapist should have as a goal the outlining of certain aspects of the defensive systems that operate between the patient and the other persons with whom the patient is interacting. This first step is to designate the defenses and how they operate in interpersonal relationships. This is a precursor to analysis of the identification pattern (the “introjects,” the “not mes,” the “ego states,” the “false selves,” the “pathological object relations”).

When one works with borderline patients, a confrontation concerning the defensive patterns used in interpersonal relations is not desirable at the beginning when resistance is high. One merely outlines the behavior in detail with no comments; if necessary, one uses a projective technique to delineate the patterns. The "talking technique" is employed to define the behavior, but the therapist should speak no words that the patient can use masochistically. For example, one might proceed as I did with Maurice Belk (see Chapter 11). In my early paper (1952) I called this technique "attitude therapy." Actually, I like Don Jackson's (1957) interpretation of this type of situation: it is working with a slice of the patient's social existence as it is reflected in his relations with the therapist and with others. I believe, expanding on Clark's suggestion, that the therapist should interpret the masochism in terms of the "positive" (appeasing) transference, as it is acted out in the session with the therapist and as it exists on the interpersonal level with others. The sadistic side of the transference is referred to initially as it is reflected in relation with others. One points out first that the masochism stirs up anger or sadistic feelings toward others, in view of the self-contempt it evokes.

We can see in many of Clark's suggestions items that Eissler (1953) later considered in his paper on "parameters," or modified treatment techniques. Clark said that even though more detailed incidents are elaborated by the patient, the therapist still does not offer "regular"-type psychoanalytic interpretations and does not make particular inquiry into

childhood experiences—indeed, this is avoided. (I suggested this in 1952, not having heard of Clark at the time.) Kernberg (1975) apparently does not explore genetic origins in his early technique with the borderline. It is hoped that, as Clark pointed out, the patient will himself recall childhood experiences on his own and recognize their connection to later experiences and reactions. (This is indeed the outcome of the technique of exploring defenses, situations, and attitudes in interpersonal relationships.)

Clark insisted that in taking the role of the "perfect parent" the therapist can dilute the severity of the critical superego. The therapist supports the ego. As this is done, a questioning and investigative attitude toward "parental dictates" is to be encouraged rather than a "cringing acceptance." Here Clark made a most important point. Reducing the effects of the "punitive superego" (that is, the burden of sadomasochism and particularly guilt, anger, revenge feelings, and the fear due to the "identification with the aggressor") is a most important function of the therapist, right from the start of treatment. This must be accomplished, not by confronting the patient initially with his sadism, but by attending to several facets of the patient's problem simultaneously. We gear our technique to the understanding that masochism is functionally related to sadism and guilt. Dealing with the sadomasochistic defense at any level is one of the major problems in the therapeutic program with borderlines and involves the therapist and patient almost from the first day of treatment until the last. The problem of guilt is related to self-defeating

patterns (masochism); at the same time, as the therapist will point out, anger, reactions to anger, and self-contempt (also associated with guilt) are related to masochism as well. The borderline patient, unlike most neurotics, acts out his sadomasochistic identifications.

Clark believed that "working through" could not take place until the patient was able to do his part in the analysis, which could only be produced by adequate mothering. It is my contention that working through can begin with the first session, that is, if we look at the process as (1) the stating of some small aspect of the general problem; (2) the description of that aspect, (3) the discussion of a possible means of its solution, and (4) encouraging initial steps to be taken to change behavior so that this aspect of the problem can be solved. The goals in working through are modest in the beginning. They amount to no more than a simple clear statement of a tiny aspect of the patient's total sadomasochistic problem and consideration of what can be done regarding this small aspect. In the total psychoanalytic situation small gains are subgoals and are the only kinds of goals possible for many years.

From the point of view of "working through," the therapist must stress the masochistic modes of behavior with people (the acting out) and begin this process as soon as possible, realizing that masochism, as we have mentioned, is also a function of the low self-esteem, self-denigration, and failure in relationships. It masks to a great degree the sadism, which is a function of

revenge feelings, the *jealousy of others who are more conflict free and successful*, and the *fears* associated with acting out the aggressive wishes of the parents. As one speaks with the patient about his anger and his fears of his anger, the situations that arouse his aggression and the way that it is expressed, one delineates the patient's patterns. *The actual working through of the sadism that is connected with the aggression* is extremely difficult for the patient to tolerate; therefore, this can come later after the masochistic pattern has been broken. While Kohut (1971, 1977) does not see the sadomasochistic pattern in the same theoretical frame of reference that I do (I do not use a "gap" or a "defect" theory, and I see the sadomasochism as a *defense related to the identification with parents*), nevertheless, it seems that in working as Kohut does with the "good mother mirroring technique," he is actually attending to the patient's masochistic pattern. At the same time that he points out the denigrating qualities and equates these with some of the patient's attitudes, he also emphasizes the positive, constructive side of the patient's productions and stresses its importance.

Guilt and fear of acting out coexist with the need to act out, for in one sense action brings a temporary relief of anxiety. The acting out, however, creates another kind of anxiety as these patterns further the self-defeating mechanisms. Kohut feels that working with the narcissism, i.e., reinforcing or establishing the patient's self-esteem, reduces the aggression. This seems in line with what Clark believed, and it appears to work out that way in practice.

My feeling is that as the therapist acknowledges the patient's constructive trends, acting out is reduced, and the need for exercising the sadism turned against the self and others is lessened. The identification with the sadistic or punitive side of the parental projection is partially directed toward the self in masochism and partially directed toward others in sadism. Denial of the identification pattern in the narcissistic neuroses is, I believe, what Kernberg (1975, p. 23; 1976, p. 44) has called the "dissociated identification system." I find this pattern in borderlines too. Clark could see that in lowering the effects of the "critical superego" it would then be more possible to have a "questioning and investigative attitude" toward the parents' dictates.

Clark alleged that "the narcissist" may come upon material that may be so painful that he will return to earlier attitudes of aloofness, withdrawal, detachment, and distancing. This is the kind of resistance that necessitates, according to Clark, "modification of psychoanalytic technique." When the patient uses these withdrawing and masochistic defenses in the session, the therapist should realize that he has given the patient a premature interpretation or has spoken of something that creates an inordinate amount of anxiety. This kind of defense has been called "regression." What is termed regression, however, is actually *defensive masochistic behavior;* it is an acting out and a nonverbal way of saying, "Look, I am nothing; I am a child, an infant. I have done wrong—I have sinned." The defense is a self-denigration before the idealized image, an appeasement due to fear of aggression if the patient

were to complain of the anxiety he feels as a consequence of the premature interpretation. When the patient does complain, either he does so in a masochistic way, trying to make the therapist feel guilty for having "attacked," or he himself uses attack in defense against the therapist. Both attack and withdrawal can be a demonstration of hostility. But these maneuvers have their masochistic side, for they are meant to drive the therapist away from the cooperative relationship, which, on one level, the patient knows he needs.

When the individual, continued Clark, shows that even passively "he will drink in ("oral libido," Freud's sexual theory) what he needs from reality," then one may say that there is some possibility of his tolerating a modified technique in analysis. Clark felt that the prognosis is not at all favorable unless there can be some formation of this "secondary narcissism." The more the individual shows that he is "willing to project his libido outward in order actively to gain what he seeks in the way of love and assurances," the more possible it is that he will be capable of meeting the requirements of the second stage of analysis. He must have contacts with people and be able to relate to the analyst (therapist) and work in the analysis in a way that will "win the analyst's approval." Thus, the libido, while conditioned by narcissistic needs, is directed toward objects, and at the same time "the less these efforts have been motivated by the need for reward to the ego, the more hopeful the prognosis." One wonders, Does the patient improve or work in the therapy to please the analyst or is it because his positive moves have

given him satisfaction, which is a reinforcement of his desires for further positive moves? What is meant is that in order to be in a constructive relationship, the patient will have to give up some of his withdrawal tendencies to the extent that he can work in a positive way with another person. He will also have to give up some of his masochism and acting out. To say, psychoanalytically, that the patient should renounce his "narcissism" (withdrawal tendencies), "giving love for the sake of giving," and mean that the patient, in doing this, would not expect rewards from the relationship is being unrealistic. It is true that in a "normal" situation one must take the other person into account, but there is no relationship where the person does not expect some pleasure or reward from the other. The patient must give up withdrawal tendencies to the extent that he can cooperate in a problem solving endeavor, and he must venture a give-and-take attitude with the analyst, asking for help when he needs it, realizing that the analytic situation is for his benefit. Still another way of looking at this matter is to say that the analyst must have techniques suitable to deal with the kind of anxiety that the borderline patient manifests in interpersonal relationships, so that the analysis can proceed in a manner to resolve the patient's anxiety problems, and his defenses. (Letting the patient determine the area of problem solving is an important step in developing a therapeutic relationship.)

Clark implied that the more the patient can cooperate with the analyst in the treatment or "narcissistically use" the analyst in a way to promote his

development, the more likely he is to succeed in working through his problem. It is only when the patient can say, “I see that I am doing this” or, referring to the other, “I see what we are doing” that the analysis begins to move from the projective to the direct method of handling the transference. It may be a long time before the patient will make such admission, for it does not come easily. Prior steps involving exploration of relationship between the patient and other persons reveal their attitudes toward each other, i.e., what their verbal and nonverbal behavior indicates through their attitudes and feelings. It reveals the acting-out patterns, a defense related to identification. The exploration of relationships is an uncovering technique that is implemented prior to the analysis of sadomasochistic patterns. In my opinion, the analyst is able to reveal the defensive patterns in the very beginning of therapy by asking what happened between the patient and another person, and he seeks answers to questions about the feelings and attitudes of the two people—with no other comment (see Wolberg, A., 1973, pp. 195-206). First we reveal that patterns do exist in the patient’s interactions so that later the patient can say, “I am doing this” and “He is doing that.” Still later he can say, “I see what we are doing.” Even in the initial interview, one must explore areas that the patient is willing to discuss, areas where he has partial insight that will lead to further exploration of the problem and delineation of the defensive patterns as they operate in interpersonal relationships. Letting the patient lead in this process is an important principle.

According to Clark, the analytic probability is increased as the patient is able to give "object-love toward the analyst," for then the transference can eventually be worked through. (Here Clark is more hopeful concerning the outcome and the possible eventuality of successful analysis with the borderline patient than Kohut, for example.) If the patient begins to show some ability to face issues, to fight them and not the analysis, and to work through real experiences, then, Clark contended, there is hope for eventual insight. Too docile and cringing an ego is a handicap. The more the compensatory substitutes (the fantasies? the symptoms? or both?), the less one can face issues. The stronger the ego in these matters, the better. Clark recognized the failings of a masochistic attitude and how it interferes in any cooperative relationship. A sadistic attitude is similarly an impediment. In either case, one must in some way undermine the masochism before the "ego can gain strength." Grandiosity and self-centered attitudes were considered by Clark as narcissistic impediments to a relationship. The individual arrived at this sadomasochistic mode as a result of long-standing and persistent training on the part of the parents and other important figures.[3] It is not clear in Clark's paper whether he is using the term "compensatory substitutes" in the same sense that Kohut speaks of "compensatory structures" (Ornstein, 1978, p. 99), but this seems likely. The road into grandiosity, for example, is not seen by Clark as a sadistic defense but as a regression and a substitute for love and respect in the developmental sense.

As the objective trend ("the observing ego") develops more and more consistently and strongly, said Clark, the projections toward the analyst can be more precisely and fully understood. In describing the dynamics of the borderline patient, Clark presented a number of criteria. He alleged that the patient had not received enough "narcissistic gratification" and that a barrier had arisen between him and objects, so that interpersonal participation was difficult. Eventuating symptoms then represent forms of "substitute-gratification of narcissistic libido" (an idea that seems to be similar to Kohut's "compensatory structures"). In the psychoanalytic language of today there are attempts to redefine what is meant by "fantasy," "symptoms," and "defenses." Many investigators attempt to differentiate between these; in my mind they are all connected. Kohut distinguishes between "compensatory structures" and defenses. (I believe he means compensatory due to defects in the ego or more precisely the "self," which has a separate line of development from that of sexuality.) Masterson (1976, pp. 38-39, 55-56, 77-80, 100-112) speaks of a "structural defect," which is similar to what Kernberg (1975, p. 22) means when he speaks of "nonspecific ego weakness." Kernberg lists "ego defects" in the borderline patient as follows: inability to perceive reality, inability to differentiate object from self, inability to integrate good and bad in a single person, inability to repress aggression. Masterson would add to Kernberg's list the intensification of feelings of abandonment and acting out the wish for reunion. One might also add that Kernberg says that the borderline has an

inability to identify with others; thus he has no true identification system, no ego ideal, and no object constancy, no observing ego.

Emotional energy in the patients we classify as borderline is not directed into the usual life activities but has been "impounded within the ego," said Clark. Excessive tension was created, the neurosis then being necessary for its release. Moreover, the neurosis was a flight or a "regression" from "higher levels of development" to "a more infantile plane" where impulses might be gratified in disguised forms by means of symptom formation. The disguised forms are in Kohut's terms "compensatory structures," which are a manifestation of the ego line of development. Thus compensatory structures mean "a system of ideals and of correlated executive ego functions" as opposed to defenses (Kohut, 1971). An example of one would be obesity: metapsychologically speaking, a "pleasure-seeking oral stimulation" of the erogenous zone; clinically speaking, a "depressive eating," to be seen as a reaction to the unempathic self object, an "interpersonal consequence" rather than a "drive" or a "compulsion to eat." (We can agree that symptoms are due to interpersonal relations.) The "unresponded to self" has not been able to transform its "archaic grandiosity" and its "archaic wish to 'merge' with an omnipotent 'self-object' into reliable self-esteem, realistic ambition and attainable ideals. The abnormalities of the drives and of the ego are the symptomatic consequences of this central defect in the self" (Kohut 1971, pp. 81-83). Kohut (1971, p. 85) also assumes a concept of a "group-

self." The symptom is a reactivation of an incompleted developmental task (the Zeigarnik effect). The idealized self-object (Freud, S.E., 1921; Kohut 1971) would be a completion, according to Kohut, of that particular task. It was Breuer who advanced the idea that in treatment we give the patient the opportunity to talk about the experiences that he did not complete adequately (Wolberg, A., 1973, p. 22). In treatment he said that the individual has a second chance to deal with a traumatic memory by "recalling with affect" or by effecting an abreaction. I suggested (1973, p. 4) that these "incompleted tasks" are probably what enables a patient to engage in therapy. Kohut (1971) suggests that it is an incomplete developmental task that provides the impetus for the patient's need to be relieved of his symptoms. The symptom, Kohut asserts, is a reintensification of an attempt to "fill in" a specific "structural defect." Sexualization of the transference, encountered in the early phases of some analyses, is another example of a compensatory structure.

In my experience, these "compensatory structures" have a definite relation to *identifications with the parents* or parental figures. The few cases of obesity I have worked with were definitely a consequence of such identifications. One of my patients, Frances Krasmire, had a running dialogue with her mother and father about eating and what to eat. Her mother was chronically on a diet; as soon as she went off the diet, she gained back all the weight she had lost. She was involved with Frances over a period of many

years (until Frances was an adult) in inculcating a similar diet pattern, which Frances adopted in her early years. Frances was the "bad one" in the family while another sister was the "good one." (This pattern of "bad" and "good" seemed to be typical of families where borderline and schizophrenic patients exist.) Both the father and the mother were obsessively interested in Frances. Geraldine Girard, another patient, also had a weight problem. She identified with her mother who was "fat" and was in and out of sanitaria, for both health and weight reasons, all of Geraldine's young life. Geraldine was the only child of her father's second "late" marriage. She always thought of her father as a grandfather. The mother was beautiful but "sickly," much younger than the father. As she grew older, the mother became overweight. Mother was completely preoccupied with herself. A half sister, a child from a former marriage of the father, was both "mother" and "father" to Geraldine, her own parents having partially abdicated those roles. Geraldine often thought of her mother when she was overeating. Geraldine ate to relieve depression, which was usually associated with anger, sexual sensations (maturbatory equivalents), and a feeling of having been demeaned.

The patients I have seen who sexualized the therapeutic sessions when talking of their compulsive behavior were patients who had definite sexual encounters with their parents or parental substitute over periods of time. Some were symbolic, but most had certain physical contacts, not always direct intercourse, but stimulating and teasing physical events. Identification

with the seductive object was one basic dynamic in those cases. It is true that many patients have sexual feelings when working through the transferences. They transfer to the therapist erotic images that they had with their parents but images that they repressed. In transference the patient is working through identifications with parental figures. Those patients who tend to sexualize *most sessions*, I have found, are homosexuals or are individuals who are about to break through to a homosexual or schizophrenic adjustment. Borderline patients do not have this persistent kind of sexualizing in sessions, although like the homosexuals and other schizophrenics they have sexual and aggressive thoughts in relation to transference feelings.

Whether "compensatory structures" or "compensatory substitutes" are similar phenomena seems to be answered in the affirmative when illustrations are given, for these appear to mean symptoms, defenses, and fantasies. The meanings attached to symptoms and fantasies can be quite different, however, depending upon the general theory of borderline that is being used. One of the problems in defining these terms is founded in the nature-nurture controversy and in the individual-group concept. One is asked which of these opposites is more important in the development of neuroses and psychoses? The answer, of course, lies in the fact that they are intertwined, one does not exist without the other. The symptom is not without its mental and neurophysiological components. We are talking, of course, of neurotic symptoms. If we take for an example a derealization

episode, we find that in the dream structure that is intrapsychic and "structural" (i.e., containing elements of id, ego, and superego) the memory of the incident might show up in the form of "people who are mere shadows" or the patient might say, "I was there but not part of it," a defense of denial. We see in the manifest content that the mental event has a relation to an interpersonal or group experience. The mental event includes the defense. The dream represents a need of the patient to blot out the memory of a situation that occurred in the past, a memory that is being revived by some situation in the present. In order to repress the memory in the face of the current stimulus, the patient resorts to a derealization maneuver in the dream. If we pursue this symptom (defense), we shall find that the defense is against the memory of a sadomasochistic event, or more likely a series of sadomasochistic events, and will have a relation to the ego ideal in that there has been an idealization of the parents, since it was they who originally evoked a sadomasochistic milieu. Rickman (1926) felt that the superego was a way of *maintaining object relations,* presumably with the parents. This is a little different idea from that of Freud, who felt the superego was a way of controlling bad instincts by way of identification, a precoursor of which was the ego ideal. (My concept is that the id should refer to the autonomous behavior.)

Freud (1921) associated symptoms with identification and the oedipal problem and considered the stimulus for identification to be derived from an

"inner urge" (derivation of the id?) on the part of the child to oust the parent of the same sex and take the role of that person with the parent of the opposite sex. (There were occasions, of course, when the child took the parent of the same sex as object.) The symptom, Freud thought, was a punishment, a kind of atonement for the oedipal wish. Often the symptom is a punishment, and in my terms it is associated with the hostility and revenge feelings that the child develops over time when he is controlled and forced into the identification with the parents.

Identification, in the neurotic sense, then, would mean that the stimulus comes from the parent who is using the child as a projective object and in defense presses upon the child an identification role. The frustration and inhibitions that are created as the child gradually conforms to the parent's pressure for the identification evokes the tension and anger and finally the aggression and revenge feelings that are syphoned off in the acting out of the identification role. The paranoid trend is the poignant need of the individual to deny (1) the implications of his bondage in the sadomasochistic position, which eventuates out of the adoption of the identification role, and (2) the aggression that has been evoked in his interpersonal encounters with his parents, which one might call a derivative of the id.

One might also consider the aggression to have an ego factor in that it is a reaction to an actual situation of which the individual has conscious

feelings. It is correct to speak of "identification roles," for both father and mother project roles as functions of their defensive patterns. They have a neurotic need for the child to act out the roles. As a matter of fact, the father and mother come together on the basis of their neurotic needs, which I stressed in my 1960 paper when speaking of the "the parents' interlocking neuroses" and which I now specify as an *interlocking defensive system.* The identifications of the child would then be based on what Rickman (1926) called the need to maintain object relations through the ego ideal or superego, which really is a masochistic defense in the face of the parents' pressures for the child to accept the acting-out roles (Wolberg, A., 1973, p. 49). Identifications are the basis for the patient's acting-out patterns. In our example of derealization one can find both oedipal and preoedipal characteristics if we look for them in the associations to fantasies. The symptom when represented in the dream can be of a person who is considered to be cold, and unapproachable—a father. For example, one of my patients, Daird, would have a *fear* instead of *representing a memory* in his dream; at other times he would deny that a particular session was of any importance (Wolberg, A., 1973, p. 182), this being a kind of depersonalization and derealization at the same time, of both himself and the analyst and of our relationship. One must obtain associations to discover the context of the derealization. At the same time one must obtain associations to discover the context of the interpersonal situations that the symptom connotes, but one

can assume that the individuals in the interpersonal or group interactions that are blotted out contain the essence of the sadomasochistic memory and that the people in the dream have in some way reflected the patient in his identification role and the parent in his evocative stance. When the patient discusses the setting of the dream, it is obvious that his identification with his father is the important conflict in that particular session. When a symptom is represented in the dream, one is tempted to think of character problems, but when an interpersonal situation is represented, one tends to think of oedipal problems. As a matter of fact, it can be one or the other or both that is the preoccupation of the patient at the time.

The aim of treatment, according to Clark, must be (1) to remove the barriers which made it impossible for the patient's release of energy to convert to rational performance; (2) to encourage the socialized use of the tendencies already present (the developmental tendencies); and (3) to reinvoke developmental trends so that the cruder impulses can be modified and be more acceptably discharged in reality. To estimate the prognosis, we must decide, said Clark, which factors point to the greater probability of the aims being realized. The *barriers* that blocked acceptable emotional discharge were to be found (1) in the outer world, (2) in the individual ego and superego, and (3) in the nature of the impulses themselves. At first psychoanalysis could have little effect except to favor passively the environment in which the patient functioned most happily. *Within the*

individual himself we should attempt to strengthen the ego by reducing or softening its harsh superego (the hostility and its "categorical restraints"). It thus would become a more kindly guide for conduct. A weak ego required a powerful and despotic superego. The ego must be strong in order to maintain a friendly superego. Alexander and French (1946) stressed the importance of *reducing the hostility and categorical restraints of the "harsh superego. "* This can be done best by outlining the dynamics of the *masochism* and eventually showing that the "harsh superego" is in fact an internalization, that is, an identification with the parents' hostile and denigrative attitudes. When the patient threatened the parents' defenses by certain types of normal impulses and behavior, he was made to feel guilty.

Clark did imply that the parents had some responsibility for the borderline patient's dilemma even though he used the theory of narcissism and the preoedipal concept as his underlying theory of borderline personality. Apparently he felt that identification and the formation of an ego ideal had to take place in the therapeutic situation so that the patient could go on with his development.

In treatment we encourage the individual to seek contacts with the outer world, Clark said, but we must realize that when we say "direct contacts" with the outer world we mean also the quality of these contacts. The decisive question must be not only how much the ego directed the instinctual

energies into contacts with the outer world but also what kinds of contacts the ego maintained. Contact with the outer world is not necessarily synonymous with objectivity and the meaning and solving of realistic problems. When the ego can meet obstacles by redirecting itself rather than regressing into withdrawal, timidity, masochism, or narcissistic absorption, then we may say that the ego is strong rather than weak, and we may estimate progress by whether the ego is capable of doing the former. (I have found that it takes years for some borderline patients to move away from neurotic companions, but they often progress during that time in other ways.)

Stressing the need to keep in mind the characteristics of an exteriorizing "object-libido," Clark pointed out that the giving of interest and effort to the object without the expectation of return creates a satisfaction in the doing, quite apart from autoerotic pleasure or the narcissism of accomplishment. It is something by which only the object gains in any substantial way. The object is distinctly separate from the subject, something outside himself toward which he must go. In my opinion, "satisfaction in the doing" without any expectation of return simply does not exist. Indeed, why should it exist? Clark realized that complete altruism was scarcely possible since "clearly no one ever attains complete objectivity in any particular activity or relationship. What we are estimating is a component, a partial quality, not an absolute or independent factor." Clark adds: "Whenever there is a sadomasochistic reaction to the failure to gain a return it clearly indicates the narcissistic

element in the projection. The degree of sadomasochism would be a measure of the need for return, and hence an indication of the low level of objectivity."

When Clark wrote of sadomasochism as regression, presumably it was because the "sadomasochistic instincts," according to psychoanalytic theory, are supposed to put in an appearance at the age of 18 months to 2 ½ years, in the anal period. The "ego" is then required to tame these instincts. When this does not happen, it is due to "ego defects" as a result of poor mothering, or to heredity, or to some of each. Mahler, Pine, and Bergman (1975, p. 211) and Kernberg (1966, pp. 250-252; 1975, pp. 25-30) say that splitting is the first defense due to projective identification, and normally the defense of "splitting" drops out at the end of the second year when the infantile hostility toward the parent is submerged by repression, leaving only a minimal degree of ambivalence.

In reporting Clark's ideas, I do not wish to overstress the use of the term "narcissism," primary or secondary, as applied to the developmental process, for I believe these concepts to be largely speculative. Modern infant research clearly refutes postulations such as that of narcissism (Wolberg, A., 1977). For example, the defense of withdrawal in a child should not be considered a disorganizing, infantile "narcissistic" trait since under certain circumstances it is a very adaptive method of coping. In the analytic or therapeutic situation such withdrawal would then be a transference reaction. It is difficult to

embrace the idea of "infantile fantasies" and "regression" if we mean by regression in the borderline that the adult goes back to ideas, thoughts, and feelings he had as an infant from 4 to 16 months of age in the "narcissistic" stage where he was "fixated." Usually what is meant by "regression" is a withdrawal into fantasy, at least when a given author describes what he means. If one believes that the original mental state of the infant is a fantasy semipsychotic (id) state, then regression means going back to that state; but the presumption of such a state is an esoteric idea. Fantasy is, in fact, a sophisticated way of dealing with anxiety rather than a primitive mental form. It is an advanced form of symbolization. Searles (1963) speaks of "transference psychosis" but apparently does not suppose it to be a reflection of "regression to an autoerotic level of development."

We know that children do have fantasies when they imagine that something "bad" outside the family is menacing their existence. The hope is that the family is "good." We can say from experience with children that a protective fantasy, a projection, begins after the age of 2 ½ or 3, whenever a child begins to experience fear associated with shadows on the wall representing animals or creatures that are "dangerous." It is the fear of parents that makes the child project the object or, in more precise terms, use denial and projection, idealizing the real family members.

A most valuable part of Clark's treatment seems to have been the

emphasis on the patient's constructive capabilities along with analysis of some of his neurotic behavior patterns.

The psychiatrists before Clark and Eder had no knowledge of dynamic concepts; yet they treated patients both on long-term and short-term bases with good results for the most part. We would think that the main vehicle for their success would be the kind of empathic relationship they established with their patients since the measures they used in their symptomatic approach were of no great significance. These early psychotherapists, however, noted a great deal about the behavior of their patients. Eder (1914), Clark (1919), and Stern (1937) seem to be the earliest observers in the psychoanalytic field aside from Freud (1919) regarding the borderline patient. Stern emphasized the importance of the mother in the child's emotional quandary.

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Notes

1 Kety has called these types of cases borderline schizophrenia, and there are estimates by him and some of his colleagues of genetic factors being involved ranging from 8 percent to 44 percent, depending upon which investigator makes the calculation (Goldstein & Jones, 1977; Kety, Rosenthal, Wender, et al, 1971).

2 Two interesting papers have been published recently in which the authors advocate a similar technique approach—"The Role of Didactic Group Psychotherapy in Short-term Psychiatric Settings," by Andrew B. Druck (1978) and "The Rationale for the Use of Group Psychotherapy for Borderline Patients on a Short-term Unit" by H. D. Kibel (1978).

3 I believe that we shall have to recognize that neuroses and psychoses are not made in the first and second years of life as some therapists currently suppose; rather they develop gradually over a number of years. In the therapeutic session, even as the patient defends, he describes his problem and indicates his "compensatory substitutes," as one can see by the patient's statements in my initial interview in The Borderline Patient (1973, pp. 195-2061, where the patient James tells me that he is rigid and has obsessive-compulsive mechanisms and tends toward hysterical (or psychotic) reactions and that his resistances are strong even when he is asking for help. He has great anxiety and fear about uncovering how he feels toward his parents; consequently, it will be a long time before he will be able to work through those feelings. This is indicated by his worry about what the may have done to him. He is highly defensive using the school as a projective defense. This is not to say that the school was perfect and may not have done him some harm. He also describes his sadomasochistic patterns with his girlfriend. His fantasies interfere with his work and with his relations with people.