The Problem of IDENTIFICATION

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The importance of identification as an aspect of the neurosis was one of Freud's great discoveries, but the concept was largely neglected by him, it seems to me, due to the difficulty he had of accepting the idea of the active role of the parents in the development of the child's neurosis and their influence on the shape and form of the child's emotional condition. He solved the dilemma, not by evolving a logical social-psychological theory relating to identification (an interpersonal process), but by organizing the mysterious libido theory and the developmental scheme (infantile sexuality I which had its roots in ancient ideas, folklore, fable, tribal procedures, beliefs, and teachings.

The theory of identification as both an interpersonal concept and an "internalization" would have been a logical outcome of Freud's theory in the "Interpretation of Dreams," where he postulated that people in the dreams had significance for the dreamer in terms of his identification with them. It is the environment that forces identification on the individual rather than the innate schedule. The

ability to imitate, which apparently has genetic roots, makes it possible to defend through identification, although the latter is a different process from imitation. It is possible that this capacity to imitate has a relation to the ability to "give in to the other" and to identify with and appease another, an enduring characteristic defense of the borderline patient.

In the family, as has been repeatedly stressed in this volume, *displacement began with the parents' projections onto the child of that aspect of their own identifications with their own parents that they* hated and wished to deny (see Wolberg, A., 1960; also 1973, p. 26, footnote SI. The child fights against the identification, but he finally accepts it and the sadomasochistic pattern it involves. The basis for his acceptance is the punishment and reward system la conditioning factor) set up by the parents as a means of forcing the child to submit to the identification role and the child's fear of danger that is inherent in the parents' aggressions in the form of punishment. Punishments include devaluation, derision, the instigation of guilt feelings, the fear of annihilation, and occasionally physical battering. As a consequence, a sadomasochistic pattern is finally established.

Parental Fantasy, Identification, Borderline Fantasy, and Acting Out

Szurek and Johnson found a relation between *the fantasies of the parents and the acting-out patterns of their children.* Reasoning that the parental fantasies are functions of the acting out of the child, we may then propose the dynamics of this kind of connection to be through the process of identification, which is an interpersonal phenomenon, registered in the mind in the form of fantasy, a repetitive fantasy (defense) representing the memories of experience with parents that led to the identification. The repetitiveness of the identification fantasies is an indication not only of a conflict, but also of an incompleted task: an inability to relate to the parent so that the child could reach a reasonable autonomy. There are two opposites: (II the child's need for autonomy and (2) the parents' efforts to force the child to identify with the parental neurosis.

Identification creates aggression since it is a frustrating experience resulting from the inhibitions instituted by parents over time as they demand the identification role and deny their actions in doing so. The child's aggression is a counteraction to the aggression of the parents as they inhibit certain aspects of the child's normal

behavior due to their neurotic anxieties. The aggression is also a parentally determined factor because of the need of the parent to have the child act out aggressive patterns so that the parents can gain vicarious sadistic satisfaction denying this and forcing the child to deny.

The children of these families around the age of 3 and 4 begin to organize sadomasochistic fantasies associated with their fear of annihilation due to the parental aggression as the adults enforce conditions propitious to the acceptance of the identification role. The mental representations of this struggle are sadomasochistic fantasies that are depictions of various experiences with parents, disguised. The fantasies are defensive in that they are products of fear stimulated by the social situations in which parental demands were forced upon the child. Part of the “self-image" is gained through the identifications that are thrust upon the child. These images are embedded in certain self-representations and together with corresponding object representations they are reflected in the child's fantasies. These take the form of what have been called “basic fantasies,” i.e., “beating fantasies,” “family romance fantasies,” and the like. The romance fantasies appear around the ages of 7 to 10 years, while the beating

fantasies may begin as early as 4 or 5 years of age. Prior to the beating fantasies the dread of annihilation is expressed in fears of shadows on the walls, fears of falling asleep, and the like.

The "Self" vs. the "Self"

There is another side of the self-concept or the self in the picture of the individual's condition. This aspect contains the opposite of the images based on the projections of the parents (these communications that contained the neurotic demands of the parents to act out the identification role). They represent the opposing forces in the self that have to do with the child's understanding of his *differences from his parents,* the self *he is* and *would like to be* were it not for the necessity of acting out the identification role. There is a polarity in what the child wants to be in his uniqueness as opposed to the role his parents need from him to quiet the parents' neurotic anxieties. The fantasies are the internalizations or representations in the mind of the several polarities that make up the total conflict of the child's dilemma. The fantasies, like the child's dreams, tell the historical story of these opposites. The exaggerations in the borderline patient's dreams and fantasies are residual of the early fears the patient had as a growing

child when he was overwhelmed by the aggression and punishments inherent in the controlling mechanisms of the parent. To counteract these fears, the child *remade reality* in the form of idealizations and “cover" memories, such as one sees depicted in the “family romance."

In the early stages of life, when identifications are reluctantly being incorporated into the behavioral pattern of the individual, the child can react with temper tantrums (Geleered 1945). fears, depressive phenomena, and eventually symptoms, inhibitions and behavior patterns that are organized around a passive-aggressive sadomasochistic character with a periodic acting out of the identification roles in times of unusual stress. The neurosis (or psychosis), based on these sadomasochistic interpersonal relationships within the family, is important in the family but an impediment to adequate adjustment in the larger society. The patterns of interaction that the individual develops are meant to reduce stress, but they cause the individual a different kind of stress. “Identification" means that the child has adopted actual behavior patterns that correspond to the communications that he has received from his parents to act out certain roles that will relieve the parents' anxieties (Wolberg. A., 1960). The roles are destructive not only to the patient

but also to the others with whom he interacts. The fantasies that the individual organizes are sadomasochistic in character, for this is the nature of his experience with caretaking persons as expressed in their anxieties for control.

The Defense of the Identification Defense

The identifications in the borderline patient are defended against by a process of projection; thus we say that the basic defense is one of *projective identification.* These projective defense phenomena are associated with denial of certain aspects of the identification roles and the acting out of these roles. The parents demand the denial of what is going on in the family, and a condition (distortion of judgment) such as Asch (1951) demonstrated in his research with groups seems to exist. (Group pressure if sufficient will cause a person to deny reality.) This dynamic in the acting out of an identification role is typical of the patterns of interactions of borderline patients (Wolberg, A., 1968).

At the same time that there are the denials of reality, the patient “knows" the reality but represses his knowledge, usually refusing to act upon it. Thus a duality exists in his mind: “He knows but he does

not know," as Freud put it, and this is another source of conflict for the patient. The patient has two systems at work counteracting each other: his *reality system* and his *denial system*, reflected in the mind in his sadomasochistic fantasies (identification fantasies).

The pull toward neurotic behavior is great since it has been used as a means of compromise in his conflict, and in the family it was life saving in that it was in obedience to the parents who needed his behavior. The individual has been made to feel responsible in a sense for the equilibrium of the parents, to his own detriment (Jackson, 1957). He builds resentment, anger, and finally revenge feelings (Searles, 1963), defenses against which he must develop counterdefenses. He becomes susceptible to the demands of others in view of his acquiescence to his parents. He has acquired the trait of susceptibility in that he is prone to "identify with the aggressor." He defends with all of his strength against acknowledging this fact, for in such acknowledgment he would have to face his sadomasochistic traits. He is particularly defensive insofar as his sadism and sexual perversion are concerned. The patient can use idealization, distancing, denial and other mechanisms to control the therapeutic situation.

In one session Sonia said to me. “I have three different reactions to three different people—you. Dr. Wolberg. and Dr. X. With you I cry a lot; with Dr. Wolberg I feel I can’t get through—there is an impenetrable barrier. I try humor; I try many other approaches and *there is nothing.* With Dr. X I have a good time. I can feel free to express myself. I can be active. He is crazy, of course.” Dr. X appears to me to have a Reichian approach in that he utilizes techniques like touching and has a theory that there is an interruption of the life-energy flow due to repression and that this effects seven rings of “muscle-armoring.” By manipulating these rings progressively from head to feet conscious awareness of painful vegetative sensations occur and energy flow is encouraged. Dr. X uses Gestalt methods too, and he does do interpreting of a psychodynamic nature. For example, he told Sonia that she was very defensive when talking of her parents, something I had pointed out as well. It seemed that when Dr. X told her the same thing she was more inclined to talk about it than when I spoke to her —not once but many times—of this defense. A defense of the parent is one of the reasons for the negative therapeutic reaction. This is a passive aggressive maneuver but a defense with sadistic overtures. In the case of the borderline it relates to an oedipal reaction to people

about which the patient has tremendous guilt. The Oedipus complex usually means that the child has been used as a sexual object as well as an object of scorn and derision, a stance that is often a sexualized power feeling of the parent. Free association is the method by which the individual catches conscious glimpses of his repressed ideas and feelings, those ideas that are related to the meaning of his fantasies and his oedipal behavior. He begins to see the connection between his fantasies and his neurotic reactions to the present and his past life. The borderline patient does use free association but it is a denied aspect of his productions as long as he defends against the reality picture of his parents and utilizes the idealization of them that was so important to him as a child. In the borderline patient the defense of the parents is a defense of the patient's sadomasochism and an idealization of it. The defense is strong because it helps to contain the patient's rage and anger, but it also enables the patient to deny that he was rejected and abused by his parents, and that he now is like them in certain respects. This denial is particularly strong with regard to the sadistic perverse traits.

Depression is bound up with the sadomasochism in the sense that the patient feels he cannot or *should not* be glad, happy, have a

good life. As Sonia, my patient, explained to me. “I had a very enlightening experience with Dr. X. He told me to stand on one foot, as long as I could possibly do so. He put a pillow down for me when I would need to fall. When I got so tired I could not stand any longer, I fell to the floor, but I did not use the pillow. When Dr. X asked: ‘Why did you not use the pillow?’ I responded, ‘Because I’m not supposed to. Can’t see it! I’m not supposed to be comfortable or happy.” “Yes," I said to Sonia, “I think we have understood this for some years, but now you *know* this is one of your neurotic feelings. It has been demonstrated to you.” “Yes.” said Sonia and was about to end the conversation about the incident, but I would not let her do so. “I have always thought it was because you had to protect your father. He had aspiration that were never fulfilled and you have succeeded where he failed. You feel guilty about that and every time I mention this you defend your father in some ways as if I were casting aspersions on his character.” “Yes," said Sonia. “The other day I was cleaning my apartment. I do this every so often because you know I always have in mind that in the end I may commit suicide and I don't want the apartment to be a mess. Well, as I was cleaning I was looking at some old photographs, one of my father. I realized as I looked at the photograph that he was a weak man.” I

said, “I have never heard you say anything like that about your father.” “No,” she said, “In our house my father was a god. To me he was a god, to my mother he was a god, to my grandmother he was a god.” Sonia’s father had very high ideals; he was strict in his ideals. Actually, Sonia has these same rigid ideals and systems by which she lives. She will have to work this out before she can be free of her problems.

The perverse habits of the patient derive from the ways in which he had been surreptitiously used as a projective sexual object by the parents in the expression of their own sexually perverse impulses. The parents have had unfortunate experiences in their own families since their parents’ problems included fears concerning normal sexuality and a conflict regarding sexual role. Moreover, there is often a projection of sexual guilt onto other biological functions. A mechanism that is involved here was suggested by Levy (1932). He connected parental “gazing,” for example, with hypochondriacal ideas. It is my opinion that this use of the child’s body parts is a sexual preoccupation of the parent (a perversion) and that this parental practice is a source of the child’s hypochondriacal ideas. Such activities as parental anxieties concerning the child’s stools, the giving of frequent enemas or obsessive or compulsive talking *against* certain practices (see

Wolberg, A., 1968) are also disguised ways of perverse parental practice. Sexual identifications occur on the basis of the parental perversions.

We find in the borderline patient a "rapid shifting of defenses" (Wolberg, A., 1952, p. 695). Some analysts have thought of this characteristic as a failure of defense, as I used to think of it, but I now regard it as a *particular kind of defense against change that might disrupt the patient's equilibrium and force him to admit his identifications.* Perhaps this idea is similar to Chessick's (1977) "phobia of penetration," meaning that there is a poignant need to maintain the defenses and control situations in which the individual finds himself. In the therapeutic relationship, for example, the patient acts out the role he played with his parents and attempts to engage the therapist in the kind of sadomasochistic pattern he had with them. This is a transference reaction—a partially nonverbal performance—which is a resistance to treatment, to penetration, as it were, and it is a *pantomimic activity* with no apparent consciousness of the meaning to the patient. These pantomimic activities are the core of the defense of projective identification. Other defenses can be used in rapid succession—masochism, appeasement, idealization, repression,

undoing, withdrawal, and so on.

The reluctance in giving up the sadomasochistic pattern that is related to the identification was evident in the remark of one analyst's patient who said, "Perhaps I do not want to get well. I have been wearing a hair shirt for so long that I would feel naked without it. You may be right in what you are saying—in fact you are right, but I am afraid to take off the shirt." One of my patients, Gretchen Schwarb, said, "Will the real Gretchen Schwarb please stand up!" The opposite of the sadomasochism is the normal wish to shed the pattern and to realize what one wishes to be. The patient's reality picture includes the neurotic picture, but the realistic picture also embraces the realization that he, the patient, is not precisely like the parent and that his potentials may be quite another matter if he were not burdened with the neurosis. The denigration in the identification is reflected in such remarks as "I can never be first, only second." One father said in relation to his two sons, "James is different from John. James never really pulls his punches—he hurts when he hits me. But John's punches are feints—he never really hurts. John said that he is afraid of James, and he does what James wants because James could actually kill."

A very frustrating experience for a therapist is that the patient will behave in a constructive manner and then act out to destroy or disrupt these moves. What does this kind of activity mean? This is what my patient George Frank Quinn says happens when he wants to make some forward moves or when he would like to follow through on some successful endeavor. It has been my experience to find that in their relations parents have cut off the child's pleasure in performance in those areas that give the parents anxiety and the child eventually "internalizes" (identifies with! this pattern. In other words, the child is conditioned to do to himself what the parents did when the parent is not around, or he marries someone who will play the inhibiting destructive parental role to which he can be obedient.

While internalization and learning are similar, we should specify by "internalization" that we mean the *acquiring of a role through the specific instructions of the parents*, when we speak of the neuroses and psychoses.

In the context of my definition of identification we would consider the "internalization" the learning of a *neurotic role* specified by the parents in the interest of their maintaining their neurotic

defenses. We can use the concept of the superego in this context by adopting (Richman's idea that the superego is a form of maintaining object relations (Wolberg, A., 1973, pp. 49, 166, 252, 257). We can signify this total concept by the designation S(IA) meaning the destructive aspect of the superego based on identification with the aggressor. This must be what Freud referred to when he said that there is some connection of the superego with the id "that is at present unknown to us." One can also conceive of an SC. i.e., a superego part related to constructive behavior. These S behaviors would be distinguished from autonomous behavior IAB). Patterns associated with SIIAI are related to a parental prohibition but a prohibition that is definitely destructive to the child.

My case histories are filled with examples of these behavior patterns. Flora O'Toole Levy's husband (a physician) told her it was "nothing" when for two years she talked of a lump in her breast, asking him what he thought about it. His response meant "Don't go to a doctor with that complaint; it's nothing!" or "I hope you drop dead!" This was a very destructive attitude on his part and a "susceptibility" on her part to obey the authority even if the authority is irrational—this is a result of S(IA). When she finally did go to the doctor, it was

cancer. Flora always said that her mother was irrational and destructive. She was an “ignorant uneducated Irish maid," basically a “stupid woman.” Her father had run away from the mother when Flora was 5 years old and was never heard from again. The mother was inconsiderate, and she would “take no nonsense” from Flora, who had to do exactly as the mother wished. When Flora was 14 years of age, she did challenge, screaming at her mother and calling her stupid and irrational. She was locked in a room. The police were called, and she was taken to Bellevue Hospital (in New York City) on her mother's complaint that she was dangerous. After hearing her story and talking to the mother, the doctor in Bellevue advised Flora to leave home as soon as she could find a job. Flora's younger brother did leave home at an early age. He became an alcoholic, however, and died in an automobile crash with his wife “while driving under the influence of intoxicating beverages."

George Frank Quinn’s father had no patience to show him how to do anything and would always take on the task himself. He would never help Frank build with his blocks, and later Frank was criticized by his parents for being inept; “You do not known how to handle money; you cannot learn to drive a car; you will fail at physical games;

it is funny the way you act," and so on. The father suggested ineptness in his child by his attitudes. Kurt Blair's mother said, "You are sick with asthma, you can't play football, you can't engage in sports, you can't go with the other boys," and so on. Kenneth Wolcott's and Doris Berman's parents had a "yes, but" syndrome. "Are you sure this is what you want?" This will be like the other thing you did, you'll lose interest and never finish it." "It's a *good* idea hut I don't think it will be good for you." "You say you want to do it *but* it will interfere with your summer work." "It's nice to do *but* we can't afford it." "It's good food *but* too much is dangerous." Flora Levy, when she had children, usually managed to create a ruckus in the house whenever her sons had to pass an examination at school; as a consequence they often failed. James Weber failed three times in three tries at medical school. Each time his father had great misgivings about his son's motivations for going to school. He was always admitted on the basis of his tests and his marks, *but* he could not stay due to study problems. These difficulties did not present themselves in the graduate schools of psychology. His father, a doctor, was proud of being a physician and often talked of the stiff competition in getting through medical school, "a stiff competition that many people cannot stand up to."

The “I do not want to get well” syndrome that we find in borderline patients has to do with these “yes but” experiences or the “you can’t do this" type of attitude or the “oh it’s nothing” denial of importance on the part of the parents. Some consequences of this problem are the acting out of a help-rejecting transference, trying to gain punishment from the therapist, exercising aggression, being masochistic, being sadistic, and being teasing; having self-contempt due to the pattern of not winning or being second best in social situations.

Many of the acting-out patterns have to do with sexual equivalents and perversions such as exhibitionism, voyerism, and other symptoms that have sadomasochistic implications. Voyerism and exhibitionism have a secretive aspect that has meaning to the observer and the exhibitionist. They are forms of acting out by secret body language, accompanied by word language meant to disguise the meaning of the body language. Projection is a factor in this operation —more precisely, projective identification. The parent has been secretive in his communications as he set about to inculcate the neurotic role in the child. If he is actually confronted with his behavior, in a direct way, he will punish the child and make him feel guilty.

In both voyerism and exhibitionism roles are interchanged and reversed in the mind's eye, so to say, and the sadomasochistic acting out is in fact a masturbatory equivalent, a picture of a fantasy, if you will, of the object of the masturbatory satisfaction. Both the voyeur and the exhibitionist convey the response they need from the other, be it sexuality with scorn or some other form of devaluation. This is a sadomasochistic love, the only kind of love the individual is used to—a transferential object in the context of denying the reality of the sexual interchange.

James Fuchs (Wolberg, A., 1973, pp. 252-253) acted out a Peeping Tom masturbatory experience when he was in the army that was a continuation of a practice he had at home. At home he excited himself by looking into the neighbor's windows. He acted out also on the subway by rubbing his elbow against the place where he could feel women's breasts particularly their nipples. This was an especially dangerous perversion since he ran the risk of being picked up by the police. James said that it was amazing how many women tolerated this rubbing experience without moving away. In the sessions he finally verbalized the wish to rub the therapist's breasts with a kind of "Tea and Sympathy" fantasy. His mother, of course, had used him as a

sexual object in that it was her habit to accompany him into the bathroom, “watching" him as he performed his various duties. Later she added the practice of going into his bedroom after he came home from a date to receive blow-by-blow descriptions of his relations with girls. His behavior would be an identification with the aggressor (mother) to form a section of the superego that would be reflected in the identification fantasy as an impulse to act out by putting one’s self in danger in order to appease the object. The perversion is a secret communication with the object. James felt that in sexual relations with his wife he experienced no sexual thrill, and after sex he usually retired to the bathroom to masturbate using a sadomasochistic fantasy. We might depict these various perverse acts as MTP (SIA), i.e.. a pattern based on a mother transference that results in the sadomasochistic acting out of a perversion using another as an object.

Parents can use each other in these perverse ways. The father transference would be a perverse pattern based on identification with the father. The acronym translated is MTP or FTP = mother or father projected transference, acted out on a pantomimic level = sadomasochistic fantasy that is related to SIA, i.e., that part of the superego that is a function of the identification with the aggressor.

There are many forms of acting out these transferences.

Projective identification consists of utilization of the projections of the parents (onto each other or diverse objects)—projections that are in fact denied identifications (unwanted) with their own parents. There is a self-hatred involved, both in the parent as he projects the roles and in the child as his acceptance of the neurotic identifications becomes a reality. The child is disgusted with himself, and this lowers his self-esteem. This is augmented by the fact that the interlocking defensive system is binding, and the patient's neurosis has kept him from seeking the peers whom he needs in his development. At school and in social groups he is usually rejected by the more "normal" children. Consequently, he has to join groups of peers who have neurotic traits for example, ("odd-ball" groups, delinquent groups). This prevents him from developing the kinds of social skills that are necessary in normal emotional living so that he perpetuates his neurotic behavior and seeks out those who help him perpetuate it, to his detriment. There is a rejection of certain aspects of the child's autonomous behavior due to the parents' anxieties.

The rejection of the child by the parents creates a sadness in him

and guilt, along with defenses to deny the condition. The patient will be rejected by healthy members of the opposite sex due to his perverse habits, not the least of which may be frequent spells of impotence. Thus the oedipal problem should be reinterpreted to mean that the parents, in their disturbed sexuality, stimulate the child in perverse ways due to their own anxieties. There is hostility in closeness, since transference feelings are readily aroused in intimate relations. Detachment, undoing, and other destructive actions are used to break up intimacy at certain periods. Closeness evokes intense hostility, which the patient wishes to avoid, for he does not want to break up the relationship entirely. He needs the sadomasochistic experience with a member of the opposite sex. Normal reciprocity has never been experienced by these patients, thus the frustrating image that accompanies all relationships both sexual and nonsexual. When the participants have attempted sex. they have usually been disappointed—he could not have or maintain an erection at times, she could not have an orgasm, she could not *feel* or rather *denied her feeling and excitement.* There are then two images superimposed upon the efforts to have sex: (1) the image of the parents and their rejection of their parental sexuality, the opposite parent pushing the child

toward the parent of the same sex, and (2) the frustration that the individual has “internalized” with which he is now “identified" (more precisely conditioned! so that he cuts off the pleasure himself. This is an internalization of a neurotic pattern, an internalization of the identification roles as depicted in a theme related to associations to a dream or in the flow of the session that relates to a particular theme. The “internalization" is in fact a fantasy, or, to be more precise, a cluster of fantasies.

The representations of the roles associated with the identification fantasies, which were in the beginning distortions of reality, actually became associated with reality in the sense that the problem is symbolized in relations with people. The conflict is: R:D::UT:T (R=reality; D = distortion; UT = unfinished tasks; T = transference). The resolution is through analysis of T (transference). Neuroses and psychoses are realities. The conflicts are realities, complicated because they involve (1) the parents' insistence on the distortion of reality, (2) the acting out of guilt when the child resists the roles, (4) the child’s anger over the situation, (5) the disillusionment with the parents, (6) the fear of the parents’ punishment when the child challenges and how this generalizes to

create inhibitions, (7) the fear of the person's own (child's) counteraggression and hate, (8) the problems when the school or other reality gets in the way of the parents' neurotic needs, (9) the inhibitions against certain rational impulses that must be held in check in order to act out the identification roles, (10) the defenses that must go into operations so as to pursue the neurotic cause, (11) the anxiety and the physical distress of conflict, (12) the idealization of the parents, a denial of the way they actually are, and (13) the depressive mood that develops as the child feels rejected and demeaned.

Harriet Hamburger when she was working through the last phase of her treatment with me was not sure that I was not a homosexual. This problem lasted for three years during which she called herself a homosexual although she had never had homosexual experiences. She had slept with her grandmother during the period when she was 4 to 9 or 10 years old, and she felt demeaned by this experience. In all of her life experiences she felt second best, not good enough. She said she acted like a "jerk" in relations with others. She kept herself from success and worked at jobs far below her capacities for many years. Freud (1916) wrote a paper that touched on the fear of success.

Kurt Blau—Case Illustration

The following session with Kurt Blau contains several themes that are operating when the patient is about to embark on the last lap of analysis. The themes are (1) he wants success but fears it, (2) he feels he can do it, but is not sure, (3) he feels closer to the therapist but not tied, (4) he feels he can size up the therapist—see him as he really is with all his faults and all his good points, (5) he can begin to work through his identifications and defenses—particularly those that are most like the father (cruelty, aggression, detachment, perverse habits, and the like). There is a review of problems, an assessment of what has been accomplished, and what remains to be done. There is *a wondering whether* one can succeed in *"straightening out"* in view of the background, the family problems, and the stresses to which one was subject while living in the family.

Pt. How do you do!

Th. How do you do!

Pt. I was thinking about this girl—this was in my youth. She was a neighbor, planting in her garden, in the yard of her house—in the city—in Brooklyn. We went to look and to laugh at her—my mother and her brother; and I guess I did too.

Both my mother and father had rich relatives, but they never took my parents into their businesses—I told you this before—they never helped him in any way. But my father was always visiting his relatives—his mother—his brothers.

Th. Your mother and father were both big masochists when it came to dealing with their relatives. That's what you always told me.

Pt. You're right—they were always "doing good"!

Th. They didn't get any reward for it.

Pt. No—I told you about the time I lent my archery set—and I wanted it back—I only lent to my aunt's son. When I went to pick it up, my aunt said, "How do you do. What do you want?" The set was ripped, and I was disgusted. I don't know how wealthy they are, but they have everything! She never bought me a new archery set.

I want to get a car—a Lincoln Continental or a Jaguar. *[He then tells a story about work where he was trying to be helpful to someone—"trying to please"—and the whole thing backfired. He "didn't get any place."*]

Th. Trying to please—being helpful—that's part of your neurosis that you inherited from your parents.

Pt. You said it.

[He talks of a girl he saw at work—a patient in a hospital. He thinks he will have sex with her. Another patient he talks of is an

employee in a hospital; he sees her in a clinic in the city where he works. He says he gets very angry at her. She talks on and on; he wants to blow a gut. He says that when he talked to his supervisor about the case, the supervisor told him he feels impotent in the situation. He says he does not feel impotent.]

Th. If the situation is impossible, then why should you feel impotent?

Pt. This girl Clo *[the girl he saw at work]* everybody in the class *[at the hospital]* thinks there's something wrong with her. I think she really wants it—needs it—I wondered whether I wanted it too. She can't be "genital"—no object constancy—no depth of feeling, no real life pattern. Perhaps I should say "You and I can really make it together—genitally. I'll help you and you'll help me." My wife and I are having a hard time these days. I think she fends me off. She says, "Can't we have a conversation sometime? Does it always have to be sex!" Does that mean something? Is she saying something to me? Am I a sex maniac? And—I still feel close to you—I still have a feeling of wanting to touch you.

Th. In what way?

Pt. My hand

Th. Where? How?

Pt. Easiest place is to touch you on the leg—I was thinking of touching you on the breasts—just to stand and hug you. Expand with you.

Th. Hugging—embracing—being close—that sounds nice.

Pt. It's like if you can put the two doors together—they can slide—they expand. It's like the closeness, the warmth will come out, if I can expand, if I can spread out, if I can . . .

Th. Um hum. Warmth—uh huh.

Pt. I don't know if its euphoric. I don't know if its *fusion* . . . It's sort of like you should know me all the way—all of me.

Th. Uh ha!

Pt. Then I would know all of you.

Th. Yes? Well, would you?

Pt. Actually, I think I would—this is fantasy—somehow I will know you well enough to be a social friend, and my wife and I will know you well enough too. There's some kind of "other relationship" than therapy. Are you a substitute mother? People who really feel and think the way we do—There are very few people we can do this with. I'd say I can with B *[his wife].* We share most things together—we like each other.

Th. You said *euphoric* before.

Pt. It's a kind of oceanic feeling—fusion—that's what Freud *[an instructor]* talks about. *(pause)*

I feel very tired now. It's like I think I know my ego boundaries—I don't think I'm afraid of fusion—the loss of ego boundaries. I think I can be with you *without worrying;* I used to worry about

what I'd tell you.

Th You don't worry any more?

Pt. I don't think so.

Th. You're not so afraid to come closer?

Pt. I don't think I am any more—like last week. I said we never talk about closeness.

Th. Well, you were afraid of closeness.

Pt. I never knew it. but I was.

Th. Uh huh.

Pt. I was never close. I guess, to people—there was always a distance. I never felt close without guilt. The only person I ever felt close to was my aunt, and there was a lot of guilt.

Th. Guilt?

Pt. Guilt and anxiety. I don't know what you want to call it , . . . It was like I enjoyed being with her when I was a little kid. She attempted to be close. I was afraid of her husband. He was a very strict guy. a typical German Luftwaffe. In her way she's reserved . . . She mixes me up with my father—she calls me Hymie many times, that's my father's name. I remembered when I was 5 years old. She was in her nightgown. I saw her breasts. I don't know whether a 5-year-old boy wants to see breasts . . . I always have

that image of her in her nightgown with her breasts and my wanting to see her breasts.

I remember her taking a shower while I was in the coffee room—the vacuum was standing there—at 5 or 6—and I had the handle of the vacuum against my penis and when the shower stopped. I started moving the vacuum around the room.

Th. You were 5 or 6?

Pt. Yeah! At the most, 7. I once wanted her to buy me a machine gun because I saw a kid with a machine gun—but her husband thought I should have a xylophone—and I had a temper tantrum and he beat me—and gave me a xylophone—and I used the xylophone. I learned to play the xylophone. I used to be there—in their house—on the weekends. My parents would leave me there. And when my parents would come to get me—I'd put my face in the water—I'd try to look at ships—I'd get goose pimples.

Th. You mean you didn't want to go home—you'd get goose pimples when you got home?

Pt. Yeah. I'd like it there . . . I remember my father—he'd go work at his mother's house on the weekend.

Th. You mean every weekend?

Pt. Every Sunday that he wasn't working—he'd go over to his mother's. It was very rare that he'd go anywhere else on a Sunday—to his mother's or to his brother's. She'd be waiting to give him some . . .

Th. What?

Pt. He'd fix things—go do it—fixing locks—working for nothing. My mother used to scream at him for doing this. He was always running out—to his mother's. She'd want to go some place—relax—he'd go to his mother's or brother's every time.

Th. Maybe he felt himself isolated from people that way.

Pt. I don't know how he developed it. He used to work with his father. His father he tried to please, I guess . . . All the others moved out—went on their own. He had to please his father. The other brothers got free. My father always had a lot of resentment toward his father. He resented going to religious school Saturday afternoons. I'm sure he had a lot of resentment.

Th. Resentment for what reason?

Pt. For what reason! His father never let him be—never let him get away—he was always on him in a sense—demanding from him. His father gave him a bike, but heavy duty, for delivering ash cans. I never got a bike . . . He always promised me one, but I never got one. My father could never do anything for sheer pleasure—bike work—for work—but no object for just pleasure. I think he was tied to his mother besides—I think he would wish to be tied. He was the youngest in the family.

Th. The youngest?

Pt. The youngest—at least four or five—brothers—two sisters that I know of.

My mother is the youngest also; she too has four or five brothers and two or three sisters. She was never close to her father—he lived in the basement—he was an iron worker—I've never seen any affection between them. My uncle used to say that when my grandfather would shake hands blood would come out of the hands . . . He would say he tried to match strength shaking hands, but he couldn't win.

TH. Which uncle was that?

Pt. My aunt's husband—the aunt I liked. I never saw any affection between my grandfather and any other human being—mother's mother died when she was young. My mother's sister had multiple sclerosis—she married an alcoholic—she must have been a schizophrenic . . . When I'd see her, she always looked out the window. She starved herself—to death—she sat there—a living death—nothing—some welfare worker would come there and sit with her—once a week. Fucked-up household! One of my uncles lived on the top floor . . . Another uncle was quite old—then he just left them—after the first uncle's wedding he just walked out and left—they don't know why—all his rage. He was the one that got the most gifts—he was the "good" one—he never came back. I even tried to be close to him once . . . He tried to help me—he said "Why don't you get out?" When I got older, "Why don't you get out?" I really did not know what he was talking about at the time. The cousin who lived underneath me—he left too (the other side of the family); they went away. The wealthy relatives I never knew. Everybody was so really estranged—no closeness. The other woman who was close was a blind woman, my Aunt Alicia. Her husband had a heart attack—on the street—

they think he was drunk—died at 28. He was under a strain too, always broke—he dropped dead running for a bus—no one gave a shit. His wife was left with four kids. Everybody said "Fuck you." They got a lot of gifts—I went to the wedding—It's bizarre. I'm exhausted.

Th. I'm a little confused about the relationships, but do you mean all these people were living in the house—the same house you were brought up in? Had they all lived at one time or another in either the upstairs apartment, or the downstairs apartment, or the basement?

Pt. That's right.

Th. Your sister and her husband now live in the upstairs apartment? Or they're going to live there, and you are going to move, perhaps to Manhattan. But you don't live in the house now.

Pt. I guess I'd like to have a cigarette. You said you gave up cigarettes—you don't smoke.

Th. I did at one time, but I gave it up—heart palpitations—the symptoms went away when I stopped smoking. Anyway you've had a difficult time talking about your family—these families—and you are exhausted . . . You want to get some relief or relaxation from smoking. It was a difficult household . . . But things seem to be straightening out for you anyway. Do you feel guilty about that? I guess so.

Pt. Yes, in a way. Not so much anymore.

The *guilts* of these borderline patients are very strong and often so unrecognized, just as the mild depression that attends the guilts. Guilt, like masochisms, is evident in almost every session and must always be recognized. Guilt about aggression, about sexuality, about normal impulses, about stepping out of the identification role, about forward moves in therapy, about leaving therapy, etc. Unlike Sonia and Harriet, Kurt worked through his problems in eight years. At this point Kurt is entering the third stage of treatment described in Chapter 9.

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