

Aggressivity, Narcissism, and Self-Destructiveness in the Psychotherapeutic Relationship

New Developments in the Psychopathology and Psychotherapy of Severe Personality Disorders

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Chapter 1 A Psychoanalytic Theory of Personality Disorders

Why is it important to attempt to formulate a psychoanalytic view of the etiology, structure, and mutual relations of the personality disorders? First, because of recent advances in the psychoanalytic understanding of particular types of personality disorders, and second, because of persistent controversies in psychological and psychiatric research concerning such issues as (1) whether categorical or dimensional criteria should be used for classifying these disorders, (2) the relative influence of genetic and constitutional, psychodynamic, and psychosocial determinants, and, most important, (3) the relation between descriptive or surface behavior and underlying biological and psychological structures.

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CATEGORICAL VERSUS DIMENSIONAL MODELS

A major problem is the understanding of the psychopathology of these disorders—that is, how the various behavioral characteristics of any particular personality disorder (such as the borderline, the narcissistic, and the antisocial) relate to one another and to their predisposing and causative factors. Empirical researchers studying specific personality disorders have attempted to pinpoint the etiological factors but have repeatedly found that multiple factors appear to combine in the background of any particular disorder, without a clear answer as to how these factors relate to one another (Marziali 1992; Paris 1994a; Steinberg et al. 1994; Stone 1993a, 1993b).

Researchers using a dimensional model usually carry out complex factor analyses of a great number of behavioral traits in order to find a few overriding characteristics that, in combination, seem to apply to clinical descriptions of particular personality disorders (Benjamin 1992, 1993; Costa and Widiger 1994; Widiger and Frances 1994; Widiger et al. 1994). This approach links particular behaviors and lends itself to the establishment of a general theory in order to integrate the major dimensions arrived at by statistical analyses. So far, however, these dimensions seem to have been of little use for clinical purposes. (A notable exception may prove to be Benjamin's [1992, 1993] "structural analysis of social behavior," a model strongly influenced by contemporary psychoanalytic thinking.)

A currently popular dimensional model, the five-factor model, synthesizes numerous factor analyses into the proposal that neuroticism, extroversion, openness, agreeableness, and conscientiousness constitute basic factors that may describe all "officially" accepted personality disorders in DSM-IV (Costa and Widiger 1994; Widiger et al. 1994). But are these really fundamental determinants of the organization of the normal personality or even of the personality disorders? Factorial profiles developed for the various personality disorders on the basis of these five factors have a quality of unreality for the experienced clinician.

Researchers who maintain a categorical approach to personality disorders—usually clinical psychiatrists motivated to find specific disease entities—tend to study the clinically prevalent constellations of pathological personality traits, carry out empirical research regarding the validity and reliability of the corresponding clinical diagnoses, and attempt to achieve a clear differentiation among personality disorders, keeping in mind the clinical relevance of their approaches (Akhtar 1992; Stone 1993a). This approach, pursued in DSM-III and

DSM-IV, has helped to clarify—or at least to permit clinical psychiatrists to become better acquainted with—some frequently seen personality disorders. It has been plagued, however, by the high degree of comorbidity of the severe types of personality disorders and by the unfortunate politicization of decision-making, by committee, of which disorders to include and which to exclude in the official DSM system and under what labels (Jonas and Pope 1992; O. Kernberg 1992a; Oldham 1994). For this reason, a common personality disorder such as the hysterical personality has been excluded while the depressive-masochistic personality disorder, excluded from DSM-III, has reemerged as “depressive personality disorder” in the appendix of DSM-IV, shorn of the masochistic component previously “tolerated” in DSM-III-R under what was then the politically correct title of “self-defeating” personality disorder (O. Kernberg 1992a).

A major problem of both categorical and dimensional classification systems, in my view, has been the tendency to anchor empirical research too closely to surface behavior, which may serve very different functions according to the underlying personality structures. For example, what is seen as social timidity, social phobia, or inhibition and may contribute to a diagnosis of either a schizoid or an avoidant personality may in fact reflect the cautiousness of a deeply paranoid individual, the fear of exposure of a narcissistically grandiose individual, or a reaction formation against exhibitionistic tendencies in a hysterical individual. A related problem is that large-scale research efforts necessarily depend on standardized inquiries or questionnaires that tend to elicit responses reflecting, in part, the social values of particular personality traits. For example, excessive conscientiousness has a more desirable value than irresponsibility, generosity a higher value than envy, and so on. Our very diagnostic instruments need much more elaboration and may even have contributed to some of our problems.

It is far from my intention to suggest that a psychoanalytic exploration will resolve all existing problems. I cannot at this point present a satisfactory integrated psychoanalytic model of classification of personality disorders. For psychoanalytically oriented research has also been limited by the difficulty of assessing abnormal personality traits outside the clinical situation, the enormous difficulties inherent in carrying out research on the psychoanalytic situation itself, and the controversies that have developed within contemporary psychoanalysis regarding treatment approaches to some personality disorders—for example, the borderline and narcissistic personalities.

A psychoanalytic study of patients with personality disorders undergoing

psychoanalytic treatment, however, allows us to observe the relations between the patient's several pathological personality traits, between surface behavior and underlying psychic structure, between various constellations of pathological behavior patterns as they change in the course of treatment, and between motivation of behavior and psychic structure, as well as changes in the patient's behavior and shifts in dominant transference patterns. In fact, the joint evaluation of a patient's motivation, intrapsychic structure, and therapeutic changes provides important information regarding the origins, functions, and mechanisms of these changes in patients with personality disorders.

In addition, the observation of infant-caregiver interactions from a psychoanalytic perspective, the study of the effects of early trauma on the development of psychological functioning, and efforts to link these observations with the study of early development from behavioral and biological perspectives should mutually enrich these fields. Perhaps more important, the psychoanalytic approach to personality disorders permits, I believe, the development of particular techniques to deal with the specific transferences of these disorders and to obtain significant characterological change as a consequence of shifts in transference patterns—a clinical observation that still needs to be grounded in empirical research. In this connection, some of the subtle aspects of the differential diagnosis of the personality disorders facilitated by a psychoanalytic approach permit us to establish prognostic indicators such as the differentiation between the narcissistic personality disorder, the malignant narcissism syndrome, and the antisocial personality proper (Bursten 1989; Hare 1986; P. Kernberg 1989; Stone 1990).

TEMPERAMENT, CHARACTER, AND THE STRUCTURE OF THE NORMAL PERSONALITY

To begin, I shall refer to temperament and character as crucial aspects of personality. *Temperament* refers to the constitutionally given and largely genetically determined, inborn disposition to certain reactions to environmental stimuli, in particular, the intensity, rhythm, and thresholds of affective responses. I consider affective responses, especially under conditions of peak affect states, to be crucial determinants of the organization of the personality. Inborn thresholds for the activation of positive (pleasurable, rewarding) and negative (painful, aggressive) affects represent, I believe, the most important bridge between biological and psychological determinants of the personality (O. Kernberg 1994). Temperament also includes inborn dispositions to cogni-

tive organization and to motor behavior such as the hormonal, and in particular, testosterone-derived differences in cognitive functions and aspects of gender role identity that differentiate male and female behavior patterns. Regarding the etiology of personality disorders, however, the affective aspects of temperament appear to be of fundamental importance.

Cloninger (Cloninger et al. 1993) related particular neurochemical systems to temperamental dispositions that he called “novelty seeking,” “harm avoidance,” “reward dependence,” and “persistence.” I question his direct translations of such dispositions into specific types of personality disorders in the DSM-IV classification system, however. Torgersen, on the basis of his twin studies of genetic and environmental influences on the development of personality disorders (1985, 1994), found genetic influences significant only for the schizotypal personality disorder; for practical purposes, they are significantly related to normal personality characteristics but have very little relation to specific personality disorders.

Another major component of personality, *character* refers to the dynamic organization of the behavior patterns that reflect the overall degree and level of organization of such patterns. Whereas academic psychology differentiates character and personality, the clinically relevant terms “character pathology,” “character neurosis,” and “neurotic character” refer to the same conditions (called personality trait and personality pattern disturbances in earlier DSM classifications and personality disorders in DSM-III and DSM-IV). From a psychoanalytic perspective, I propose that *character* be used to refer to the behavioral manifestations of ego identity: the subjective aspects of ego identity—that is, the integration of the self-concept and the concept of significant others—are the intrapsychic structures that determine the dynamic organization of character. Character also includes all the behavioral aspects of what in psychoanalytic terms are called ego functions and ego structures.

From a psychoanalytic viewpoint, the personality is determined by temperament and character; in addition, the superego value systems, the moral and ethical dimensions of the personality, and the integration of the various layers of the superego are important components of the total personality. Finally, the cognitive capacity of the individual, partly determined genetically but also culturally influenced, also constitutes an important part of the personality. Personality itself, then, may be considered to be the dynamic integration of all the behavior patterns derived from temperament, character, internalized value systems, and cognitive capacity (O. Kernberg 1976, 1980). In addition, the dynamic unconscious, or the id, constitutes the dominant and potentially con-

fictive motivational system of the personality. The extent to which sublimatory integration of id impulses into ego and superego functions has taken place reflects the normally adaptive potential of the personality.

The psychoanalytic model for the classification of personality disorders that I have proposed incorporates significant contributions by psychoanalytic researchers and theoreticians such as Salman Akhtar (1989, 1992), Rainer Krause (Krause 1988; Krause and Lutolf 1988), Michael Stone (1980, 1990, 1993a), and Vamik Volkan (1976, 1987). The normal personality is characterized, first of all, by an integrated concept of the self and an integrated concept of significant others. These structural characteristics, jointly called ego identity (Erikson 1956; Jacobson 1964), are reflected in an internal sense and an external appearance of self-coherence and form a fundamental precondition for normal self-esteem, self-enjoyment, and zest for life. An integrated view of one's self assures the capacity for a realization of one's desires, capacities, and long-range commitments. An integrated view of significant others guarantees the capacity for an appropriate evaluation of others, empathy, and an emotional investment in others that implies a capacity for mature dependency while maintaining a consistent sense of autonomy.

The second structural characteristic of the normal personality, largely derived from ego identity, is ego strength, particularly as reflected in a broad spectrum of affect dispositions, capacity for affect and impulse control, and capacity for sublimation in work and values (also contributed to in important ways by superego integration). Consistency, persistence, and creativity in work as well as in interpersonal relations are also largely derived from normal ego identity, as are the capacity for trust, reciprocity, and commitment to others, also codetermined in significant ways by superego functions (O. Kernberg 1975).

The third aspect of the normal personality is an integrated and mature superego, representing an internalization of value systems that is stable, depersonified, abstract, individualized, and not excessively dependent on unconscious infantile prohibitions. Such a superego structure is reflected in a sense of personal responsibility, a capacity for realistic self-criticism, integrity as well as flexibility in dealing with the ethical aspects of decisionmaking, and a commitment to standards, values, and ideals, and it contributes to such aforementioned ego functions as reciprocity, trust, and investment in depth in relationships with others.

The fourth aspect of the normal personality is an appropriate and satisfactory management of libidinal and aggressive impulses. This involves the capacity for a full expression of sensual and sexual needs integrated with tenderness

and emotional commitment to a loved other and a normal degree of idealization of the other and the relationship. Here, clearly, freedom of sexual expression is integrated with ego identity and the ego ideal. A normal personality structure includes the capacity for sublimation of aggressive impulses in the form of self-assertion, for withstanding attacks without excessive reaction, and for reacting protectively and without turning aggression against the self. Again, ego and superego functions contribute to such an equilibrium.

Underlying these aspects of the normal personality—recently summarized by Wallerstein (1991) in a set of scales of psychological capacities—are significant structural and dynamic preconditions. These terms refer to the developmental processes by which the earliest internalization of interactions with significant others—that is, of object relations—leads to a series of steps that transform these internalized object relations into the normal ego identity. I am referring to the internalization of object relations into the early ego that starts with the “symbiotic phase” described by Mahler (Mahler and Furer 1968; Mahler et al. 1975)—in my view, the internalization of fused self-representations and object representations under the dominance of a positive or negative peak affect state that leads to “all-good” and “all-bad” fused self-representations and object representations. Such states of symbiotic fusion alternate with other states of internalization of differentiated self- and object representations under conditions of low affect activation; these provide ordinary internalized models of interaction between self and others, while the initially fused internalized object relations under conditions of peak affect states lead to the basic structures of the dynamic unconscious: the id. Rather than a “symbiotic phase,” the temporary fusion of self- and object representations under conditions of peak affects constitutes a “symbiotic state.” I define the id as the sum total of repressed, dissociated and projected, consciously unacceptable internalized object relations under conditions of peak affect states. Libido and aggression are the hierarchically supraordinate motivational systems representing the integration of, respectively, positive or rewarding and negative or aversive peak affect states (O. Kernberg 1992a, 1994).

At the second stage of ego development, again under conditions of peak affect states, a gradual differentiation occurs between self- and object representations under conditions of “all-good” and “all-bad” interactions, which lead to internal units constituted by self-representation and object-representation-dominant affect. In my view, these units make up the basic structures of the original ego-id matrix that characterizes the stage of separation-individuation described by Mahler.

Eventually, under normal conditions, in the third stage of development, “all-good” and “all-bad” representations of self are combined into an integrated concept that tolerates a realistic view of the self as potentially imbued with both loving and hating impulses. A parallel integration occurs in representations of others in combined all-good–all-bad images of the important persons in the child’s life, mainly parental figures but also siblings. These developments determine the capacity for experiencing integrated, ambivalent relationships with others in contrast to splitting them into idealized and persecutory objects. This marks the stage of object constancy, or total internalized object relations, in contrast to the earlier stage of separation-individuation, in which mutually split-off, part object relations dominate psychic experience. Normal ego identity, as defined, constitutes the core of the integrated ego, now differentiated by repressive barriers from both superego and id.

This psychoanalytic model thus includes a developmental series of consecutive psychic structures, starting with the parallel development of realistic object relations under low affect activation and symbiotic object relations under conditions of peak affect activation, followed by the phase of separation-individuation, characterized by continuous growth of realistic relations under low affective conditions but significant splitting operations and related defensive mechanisms under activation of intense affect states, and, finally, by the phase of object constancy, in which a more realistic, integrated concept of self and of significant others evolves in the context of ego identity; at the same time, repression eliminates from consciousness the more extreme manifestations of sexual and aggressive impulses, which can no longer be tolerated under the effect of the integration of the normal superego.

This structural and developmental model also conceives of the superego as constituted by successive layers of internalized self- and object representations (Jacobson 1964; O. Kernberg 1984). The first layer, “all-bad,” “persecutory” internalized object relations, reflects the demanding, prohibitive, primitive morality experienced by the child when environmental demands and prohibitions bar the expression of aggressive, dependent, and sexual impulses. A second layer of superego precursors is constituted by the ideal representations of self and others, reflecting early childhood ideals that promise love and dependency if the child lives up to them. The mutual toning down of the earliest persecutory level and the later idealizing level of superego functions and the corresponding decrease in the tendency to reproject these superego precursors bring about the capacity for internalizing more realistic, toned-down demands and prohibitions from the parental figures, leading to the third layer of the superego, corresponding to the

ego's stage of object constancy. The integrative processes of the ego in fact facilitate this parallel development of the superego. An integrated superego, as we have seen, in turn strengthens the capacity for object relatedness as well as autonomy: An internalized value system makes the individual less dependent on external confirmation or behavior control while facilitating a deeper commitment to relationships with others. In short, autonomy and independence and a capacity for mature dependence go hand in hand.

THE MOTIVATIONAL ASPECTS OF PERSONALITY

ORGANIZATION: AFFECTS AND DRIVES

As I have written (O. Kernberg 1992a, 1994), I consider the drives of libido and aggression to be the hierarchically supraordinate integration of the corresponding pleasurable and rewarding or painful and aversive affect states. Affects are instinctive components of human behavior, that is, inborn dispositions common to all humans that emerge in the early stages of development and are gradually organized into drives as they are activated as part of early object relations. Gratifying, rewarding, pleasurable affects are integrated as libido; painful, aversive, negative affects are integrated as aggression. Affects as inborn, constitutionally and genetically determined modes of reaction are triggered first by physiological and bodily experiences and then gradually in the context of the development of object relations.

Rage represents the core affect of aggression as a drive, and the vicissitudes of rage explain the origins of hatred and envy—the dominant affects of severe personality disorders—as well as of normal anger and irritability. Similarly, sexual excitement constitutes the core affect of libido, which gradually crystallizes out of the primitive affect of elation. The early sensual responses to intimate bodily contact dominate the development of libido.

Krause (1988) has proposed that affects constitute a phylogenetically recent biological system evolved in mammals to signal the infant's emergency needs to its mother, corresponding to the mother's inborn capacity to read and respond to the infant's affective signals, thus protecting the early development of the dependent infant mammal. This instinctive system reaches increasing complexity and dominance in controlling the social behavior of higher mammals and, in particular, primates.

I propose that affectively driven development of object relations—that is, real and fantasied interpersonal interactions that are internalized as a complex world of self- and object representations in the context of affective interac-

tions—constitutes the determinants of unconscious mental life and of the structure of the psychic apparatus. Affects, in short, not only are the building blocks of the drives but also signal the activation of drives in the context of the activation of a particular internalized object relation, as is typically expressed in the transference developments undergone during psychoanalysis and psychoanalytic psychotherapy.

In contrast to other contemporary psychoanalytic object relations theorists, I argue that we still need a theory of drives because a theory of motivation based on affects alone would fail to take into consideration the multiple positive and negative affects expressed toward the dominant objects of infancy and childhood. I believe that a theory of motivation based on drives as well as affects permits us to account for genetic and constitutional variations in the intensity of drives, as is reflected, for example, in the intensity, rhythm, and thresholds of affect activation commonly referred to collectively as temperament. This theory also permits us to consider how physical pain, psychic trauma, and severe disturbances in early object relations contribute to intensifying aggression as a drive by triggering intense negative affects. In short, I believe that the theory does justice to Freud's (1915) statement that drives occupy an intermediate realm between the physical and the psychic realms.

Recent studies of alteration in neurotransmitter systems in severe personality disorders, particularly in the borderline personality disorder, although still tentative and open to varying interpretations, point to the possibility that neurotransmitters are related to specific distortions in affect activation (Stone 1993a, 1993b). Abnormalities in the adrenergic and cholinergic systems, for example, may be related to general affective instability; deficits in the dopaminergic system may be related to a disposition toward transient psychotic symptoms in borderline patients; impulsive, aggressive, self-destructive behavior may be facilitated by a lowered function of the serotonergic system (deVagvar et al. 1994; Steinberg et al. 1994; Stone 1993a, 1993b; van Reekum et al. 1994; Yehuda et al. 1994). In general, genetic dispositions toward temperamental variations in affect activation would seem to be mediated by alterations in neurotransmitter systems, providing a potential link between the biological determinants of affective response and the psychological triggers of specific affects.

These aspects of inborn dispositions toward the activation of aggression mediated by the activation of aggressive affect states complement the now well-established findings that structured aggressive behavior in infants may derive from early, severe, chronic physical pain and that habitual aggressive teasing interactions with the mother are followed by similar behaviors of infants (Galén-

son 1986; Fraiberg 1983). Grossman's (1986, 1991) convincing arguments in favor of the direct transformation of chronic intense pain into aggression provide a theoretical context for earlier observations of the battered-child syndrome. The impressive findings concerning the prevalence of physical and sexual abuse in the history of borderline patients, confirmed by investigators both here and abroad (Marziali 1992; Perry and Herman 1993; van der Kolk et al. 1994), provide additional evidence of the influence of trauma on the development of severe manifestations of aggression.

I stress the importance of this model for our understanding of the pathology of aggression because the exploration of severe personality disorders consistently finds the predominance of pathologic aggression. (A key dynamic of the normal personality is the dominance of libidinal strivings over aggressive ones.) Drive neutralization, according to my formulation, implies the integration of the libidinally and aggressively invested, originally split idealized and persecutory internalized object relations, a process that leads from the state of separation-individuation to that of object constancy and culminates in integrated concepts of the self and of significant others and in the integration of affect states derived from the aggressive and libidinal series into the toned-down, discrete, elaborated, and complex affect disposition of the phase of object constancy.

Whereas a major motivational aspect of severe personality disorders—borderline personality organization—is the development of inordinate aggression and the related psychopathology of aggressive affect expression, the dominant pathology of the less severe personality disorders, which I have called neurotic personality organization (O. Kernberg 1975, 1976, 1980, 1984), is the pathology of libido, or sexuality. This field includes in particular the hysterical, obsessive-compulsive, and depressive-masochistic personalities, although it is most evident in the hysterical personality disorder (O. Kernberg 1984). Although all three are frequently found in outpatient practice, only the obsessive-compulsive personality is included in DSM-IV's (1994) main list. (As mentioned above, the depressive-masochistic personality disorder is included in part in the DSM-IV's appendix [1994], shorn of its masochistic components. The hysterical personality was included in DSM-II [1968], and one hopes that it will be rediscovered in DSM-V—institutional politics permitting. In these disorders—in the context of the achievement of object constancy, an integrated superego, a well-developed ego identity, and an advanced level of defensive operations centering around repression—the typical pathology of sexual inhibition, oedipalization of object relations, and acting out of unconscious guilt concerning infantile sexual impulses dominates the personality. In borderline personality

organizations, by contrast, sexuality is usually “coopted” by aggression; that is, sexual behavior and interaction are intimately condensed with aggressive aims, and this severely limits or distorts sexual intimacy and love relations and fosters the abnormal development of paraphilias, with their heightened condensation of sexual and aggressive aims.

An early classification of personality disorders drawn up by Freud (1908, 1931) and Abraham (1920, 1921–1925) described oral, anal, and genital characters, a classification that has gradually been abandoned in practice because psychoanalytic exploration has found that severe personality disorders present pathological condensations of conflicts from all of these stages. The classification proposed by Freud and Abraham and their description of the relation between oral conflicts, pathological dependency, a tendency toward depression, and self-directed aggression still seem to be of value when limited to the less severe constellations of these disorders (O. Kernberg 1976) and is eminently relevant for personality disorders along the entire developmental spectrum, most specifically in the depressive-masochistic personality (O. Kernberg 1992a). This personality disorder, while reflecting an advanced level of neurotic personality organization, transports a constellation of oral conflicts into the oedipal realm in a relatively unmodified fashion. Similarly, anal conflicts are most clearly observable in the obsessive-compulsive personality disorder, which transports anal conflicts into the oedipal conflicts of object constancy. Yet anal conflicts are also relevant along the entire spectrum of personality disorders.

Fenichel (1945) attempted a psychoanalytic classification of character constellations into sublimatory and reactive types, the latter including avoidance (phobias) and opposition (reaction formations). He went on to classify personality disorders, or character pathologies, into pathological behavior toward the id (oral, anal, and phallic conflicts), toward the superego (moral masochism, psychopathy, and acting out), and toward external objects (pathological inhibitions, pathological jealousy, and pseudohypersexuality). This classification has also been abandoned in practice, mainly because it has become evident that all character pathology presents pathological behavior toward these psychic structures simultaneously.

A PSYCHOANALYTIC MODEL OF NOSOLOGY

My own classification of personality disorders centers on the dimension of severity (1976), ranging from psychotic personality organization to borderline personality organization to neurotic personality organization (fig. 1).

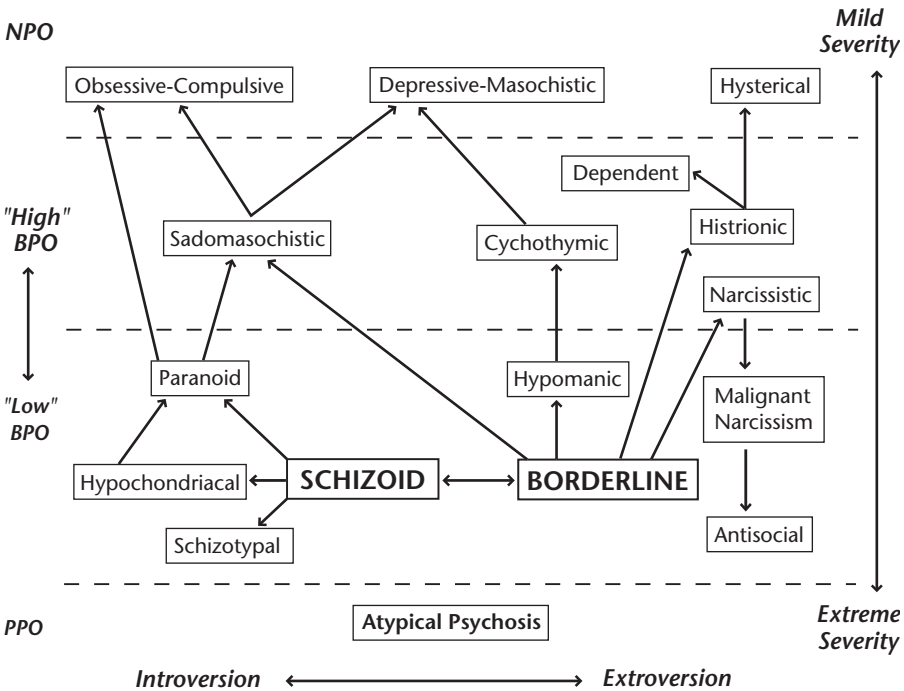


Figure 1. Personality Disorders: Their Mutual Relations

Psychotic personality organization is characterized by lack of integration of the concept of self and significant others (that is, identity diffusion), a predominance of primitive defensive operations centering around splitting, and loss of reality testing. The basic function of the defensive operations of splitting and its derivatives (projective identification, denial, primitive idealization, omnipotence, omnipotent control, devaluation) is to keep separate the idealized and persecutory internalized object relations in order to prevent the overwhelming control or destruction of ideal object relations by aggressively infiltrated ones and thus to protect the capacity to depend on good objects. This basic function of the primitive constellation of defensive operations, derived from the early developmental phases predating object constancy, actually dominates most clearly in the borderline personality organization. An additional function of these mechanisms, the most primitive, in the case of psychotic personality organization, is to compensate for the loss of reality testing in these patients.

Reality testing refers to the capacity to differentiate self from nonself and intrapsychic from external stimuli, and to maintain empathy with ordinary social

criteria of reality, all of which capacities are typically lost in the psychoses and are manifested particularly in hallucinations and delusions (O. Kernberg 1976, 1984). The loss of reality testing reflects the lack of differentiation between self-representations and object representations under conditions of peak affect states, that is, a structural persistence of the symbiotic states of development—their pathological hypertrophy, so to speak. The primitive defenses centering around splitting attempt to protect these patients from the chaos in all object relations that stems from their loss of ego boundaries in intense relationships with others. All patients with psychotic personality organization represent atypical forms of psychosis. Therefore, in a clinical sense, psychotic personality organization represents an exclusion criterion for the personality disorders.

Borderline personality organization is also characterized by identity diffusion and the predominance of primitive defensive operations centering on splitting, but it is distinguished from the psychotic organization by the presence of good reality testing, reflecting the differentiation between self- and object representations in the idealized and persecutory sector characteristic of the separation-individuation phase (O. Kernberg 1975). Actually, this category includes all the severe personality disorders seen in clinical practice—typically the borderline, the schizoid and schizotypal, the paranoid, the hypomanic, the hypochondriacal (a syndrome that has many characteristics of a personality disorder proper), the narcissistic (including the malignant narcissism syndrome [O. Kernberg 1992a]), and the antisocial. These patients present identity diffusion, the manifestations of primitive defensive operations, and varying degrees of superego deterioration (antisocial behavior). A particular group of patients—namely, those with the narcissistic personality disorder, the malignant narcissism syndrome, and the antisocial personality disorder—typically suffer from significant disorganization of the superego.

Because of identity diffusion, all those with personality disorders in the borderline spectrum present severe distortions in interpersonal relations, particularly in intimate relations with others, lack of a consistent commitment to work or profession, uncertainty and lack of direction in many other areas of their lives, and varying degrees of pathology in their sexual life. They often present an incapacity to integrate tender and sexual feelings, and they may show a chaotic sexual life with multiple polymorphous perverse infantile tendencies. The most severe cases may present with a generalized inhibition of all sexual responses as a consequence of an insufficient activation of sensuous responses in early relations with the caregiver and an overwhelming predominance of aggression, which interferes with sensuality rather than recruiting it for aggressive aims. These pa-

tients also evince nonspecific manifestations of ego weakness—that is, lack of anxiety tolerance, impulse control, and sublimatory functioning, expressed in an incapacity for consistency, persistence, and creativity in work.

Patients with a particular group of personality disorders present the characteristics of borderline personality organization but are able to maintain more satisfactory social adaptation and are usually more effective in attaining some degree of intimacy in object relations and in integrating sexual and tender impulses. Thus, in spite of presenting identity diffusion, they evince sufficiently nonconflictual development of some ego functions, superego integration, a benign cycle of intimate involvements, capacity for dependency gratification, and a better adaptation to work. This group, which constitutes what might be called a higher level of borderline personality organization or an intermediate level of personality disorder, includes the cyclothymic personality, the sado-masochistic personality, the infantile or histrionic personality, and the dependent personalities, as well as some better-functioning narcissistic personality disorders.

Neurotic personality organization is characterized by normal ego identity and the related capacity for object relations in depth, ego strength reflected in anxiety tolerance, impulse control, sublimatory functioning, effectiveness and creativity in work, and a capacity for sexual love and emotional intimacy disrupted only by unconscious guilt feelings reflected in specific pathological patterns of interaction in relation to sexual intimacy. This group includes the hysterical personality, the depressive-masochistic personality, the obsessive personality, and many so-called avoidant personality disorders—in other words, the “phobic characters” described in the psychoanalytic literature (which, in my view, remain problematic entities). Significant social inhibitions or phobias are found in several types of personality disorder; the underlying hysterical character structure that was considered typical for the phobic personality applies to only some cases.

DEVELOPMENTAL, STRUCTURAL, AND MOTIVATIONAL CONTINUITIES

Having thus classified personality disorders in terms of their severity, I shall now examine particular continuities within this field that establish a psychopathologically linked network of personality disorders. The borderline and the schizoid may be described as the simplest forms of personality disorder, reflecting fixation at the level of separation-individuation and the “purest” ex-

pression of the general characteristics of borderline personality organization. Fairbairn (1954), in fact, described the schizoid personality as the prototype of all personality disorders and described the psychodynamics of these patients: the splitting operations separating “good” and “bad” internalized object relations, the self-representation and object representation dyads of the split-off object relations, the consequent impoverishment of interpersonal relations, and their replacement by a defensive hypertrophy of fantasy life. The borderline personality disorder presents similar dynamic characteristics—impulsive interactions in the interpersonal field—whereas they are expressed in the schizoid personality in the patient’s fantasy life combined with social withdrawal (Akhtar 1992; Stone 1994).

In the course of psychoanalytic exploration, the apparent lack of affect display of the schizoid personality turns out to reflect severe splitting operations, to the extent of fragmentation of affective experience; this “empties out” the schizoid’s interpersonal life, while his internalized object relations have split-off characteristics similar to those of the typical borderline patient (O. Kernberg 1975). In contrast, the intrapsychic life of the borderline personality disorder patient is enacted in his interpersonal patterns, very often replacing self-awareness with driven, repetitive behavior patterns. The borderline patient thus evinces the typical triad of identity diffusion, primitivity of affect display (affect storms), and lack of impulse control. It may well be that the descriptive differences between the schizoid and the borderline disorders reflect an important temperamental dimension—namely, that of extroversion and introversion—which emerges under different names in various models of classification.

The schizotypal personality represents the most severe form of schizoid personality disorder; the paranoid personality reflects an increase of aggression in comparison to the schizoid personality disorder, with the dominance of projective mechanisms and a defensive self-idealization related to efforts to control an external world of persecutory figures. If splitting *per se* dominates in the borderline and schizoid personality disorders, projective identification dominates in the paranoid. The hypochondriacal syndrome reflects a projection of persecutory objects onto the interior of the body; hypochondriacal personalities usually also show strong paranoid and schizoid characteristics.

The borderline personality proper presents intense affect activation and lack of affect control, which also suggest the presence of a temperamental factor, but the integration of aggressive and libidinal affects obtained in the course of treatment often brings about a remarkable modulation of affect response. The increase of impulse control and affect tolerance during treatment confirms that

splitting mechanisms are central in the pathology. The hypomanic personality disorder, in contrast, appears to include a pathology of affect activation that points to temperamental predisposition; this probably also holds true for its milder form, the cyclothymic personality.

Borderline personality disorders presenting intense aggression may evolve into the sadomasochistic personality disorder. If a disposition to strong sadomasochism becomes incorporated into or controlled by a relatively healthy superego structure (which also incorporates a depressive potential into a disposition to guilt-laden responses), and ego identity is achieved, the conditions for a depressive-masochistic personality disorder are also present. This personality may be considered the highest level of two developmental lines that proceed from the borderline personality through the sadomasochistic to the depressive-masochistic, on one hand, and from the hypomanic through the cyclothymic to the depressive-masochistic personality disorders, on the other. This entire area of personality disorders thus reflects the internalization of object relations under conditions of abnormal affective development or affect control.

When a severe inborn disposition to aggressive reactions, early trauma, severe pathology of early object relations, physical illness, or sexual and physical abuse intensifies the dominance of aggression in the personality structure, a particular pathology of aggression may develop that includes, as we have seen, the paranoid personality, hypochondriasis, or sadomasochism and that may also characterize a subgroup of the narcissistic personality disorder.

The narcissistic personality disorder is of particular interest because in it, in contrast to all other personality disorders included in borderline personality organization, which clearly indicate identity diffusion, a lack of integration of the concept of significant others goes hand in hand with an integrated but pathological grandiose self. This pathological grandiose self replaces the underlying lack of integration of a normal self (Akhtar 1989; Plakun 1989; Ronningstam and Gunderson 1989). In the course of psychoanalytic treatment or psychoanalytic psychotherapy we may observe the dissolution of this pathological grandiose self and the reemergence of the typical identity diffusion of borderline personality organization before a new integration of normal ego identity can take place.

In the narcissistic personality, the pathological grandiose self absorbs both real and idealized self-representations and object representations into an unrealistically idealized concept of self, with a parallel impoverishment of idealized superego structures, a predominance of persecutory superego precursors, the reprojection of these persecutory superego precursors (as a protection against

pathological excessive guilt), and a consequent weakening of the later, more integrated superego functions (O. Kernberg 1975, 1984, 1992a). The narcissistic personality therefore often presents some degree of antisocial behavior.

When intense pathology of aggression dominates in a narcissistic personality structure, the pathological grandiose self may become infiltrated by egosyntonic aggression, antisocial behavior, and paranoid tendencies, which translate into the syndrome of malignant narcissism. This syndrome is intermediate between the narcissistic personality disorder and the antisocial personality disorder proper, in which a total absence or deterioration of superego functioning has occurred (O. Kernberg 1992a). In psychoanalytic exploration, the antisocial personality disorder (Akhtar 1992; Bursten 1989; Hare 1986; O. Kernberg 1984) usually reveals severe underlying paranoid trends, together with a total incapacity for any nonexploitive investment in significant others. The absence of any capacity for guilt feelings or concern for self and others, the inability to identify with any moral or ethical value in self or others, and the incapacity to project a dimension of a personal future differentiate this disorder from the less severe syndrome of malignant narcissism, in which some commitment to others and a capacity for authentic guilt feelings are still present. The extent to which nonexploitive object relations are still present and the extent to which antisocial behaviors dominate are the most important prognostic indicators for any psychotherapeutic approach to these personality disorders (O. Kernberg 1975; Stone 1990).

At a higher level of development, the obsessive-compulsive personality may be conceived as one in which inordinate aggression has been neutralized by absorption into a well-integrated but excessively sadistic superego, leading to perfectionism, self-doubts, and the chronic need to control the environment as well as the self that is characteristic of this personality disorder. There are cases, however, in which this neutralization of aggression is incomplete; the severity of aggression determines the regressive features of this disorder, and transitional cases with mixed obsessive, paranoid, and schizoid features can be found that maintain a borderline personality organization in spite of significant obsessive-compulsive personality features.

Whereas the infantile or histrionic personality disorder is a relatively mild form of the borderline personality disorder, though still within the borderline spectrum, the hysterical represents a higher level of the infantile disorder within the neurotic spectrum of personality organization. In the hysterical personality the emotional lability, extroversion, and dependent and exhibitionistic traits of the histrionic personality are restricted to the sexual realm; these pa-

tients are able to have normally deep, mature, committed, and differentiated object relations in other areas. In addition, in contrast to the sexual “freedom” of the typical infantile personality, the hysterical personality often presents a combination of pseudohypersexuality and sexual inhibition, with a particular differentiation of relations to men and women that contrasts with the nonspecific orientation toward both genders of the infantile or histrionic personality (O. Kernberg 1992a).

The depressive-masochistic personality disorder (*ibid.*), the highest-level outcome of the pathology of depressive affect as well as that of sadomasochism, characteristic of a dominance of aggression in primitive object relations, presents not only a well-integrated superego (like all other personalities with neurotic personality organization) but an extremely punitive superego. This predisposes the patient to self-defeating behavior and reflects an unconscious need to suffer as expiation for guilt feelings or a precondition for sexual pleasure—a reflection of the oedipal dynamics characterizing this disorder. These patients’ excessive dependency and easy sense of frustration go hand in hand with their “faulty metabolism” of aggression; depression ensues when an aggressive response would have been appropriate, and an excessively aggressive response to the frustration of their dependency needs may rapidly turn into a renewed depressive response as a consequence of excessive guilt feelings.

FURTHER IMPLICATIONS OF THIS CLASSIFICATION

Using the classification I have presented, which combines structural and developmental concepts of the psychic apparatus based on a theory of internalized object relations, we may differentiate personality disorders according to the severity of the pathology, the extent to which it is dominated by aggression, the extent to which pathological affective dispositions influence personality development, the effect of the development of a pathological grandiose structure of the self, and the potential influence of a temperamental disposition toward extroversion or introversion. In a combined analysis of the vicissitudes of instinctual conflicts between love and aggression and of the development of ego and superego structures, it permits us to differentiate as well as relate the different pathological personalities to one another.

This classification also demonstrates the advantages of combining categorical and dimensional criteria. Clearly, there are developmental factors relating several personality disorders to one another, particularly along an axis of sever-

ity. Figure 1 summarizes the relations among the various personality disorders outlined in what follows. Thus, a developmental line links the borderline, the hypomanic, the cyclothymic, and the depressive-masochistic personality disorders. Another developmental line links the borderline, the histrionic or infantile, the dependent, and the hysterical personality disorders. Still another developmental line links, in complex ways, the schizoid, the schizotypal, the paranoid, and the hypochondriacal personality disorders, and, at a higher developmental level, the obsessive-compulsive personality disorder. And finally, a developmental line links the antisocial personality, the malignant narcissism syndrome, and the narcissistic personality disorder (which, in turn, contains a broad spectrum of severity). Further relations of all prevalent personality disorders are indicated in figure 1.

The vicissitudes of internalized object relations and the development of affective responses emerge as basic components of a contemporary psychoanalytic approach to the personality disorders. Affects always include a cognitive component, a subjective experience of a highly pleasurable or unpleasurable nature, neurovegetative discharge phenomena, psychomotor activation, and, crucially, a distinctive pattern of facial expressions that originally serves a communicative function directed to the caregiver. The cognitive aspect of affective responses, in turn, always reflects the relation between a self-representation and an object representation, which facilitates the diagnosis of the activated object relation in each affect state that emerges in the therapeutic relationship.

A crucial advantage of the proposed classification of personality disorders is that the underlying structural concepts permit the immediate translation of the patient's affect states into the object relation activated in the transference and the "reading" of this transference in terms of the activation of a relation that typically alternates in the projection of self- and object representations. The more severe the patient's pathology, the more easily he may project either his self-representation or his object representation onto the therapist while enacting the reciprocal object or self-representation; this helps to clarify the nature of the relation in the midst of intense affect activation, and, by gradual interpretation of these developments in the transference, permits the integration of the patient's previously split-off representations of self and significant others. This conceptualization, therefore, has direct implications for the therapeutic approach to personality disorders. (The final section of this chapter describes a psychoanalytic psychotherapy derived from this conceptual framework.)

This classification also helps to clarify the vicissitudes of the development of the sexual and aggressive drives. From the initial response of rage as a basic af-

fect develops the structured affect of hatred as the central affect state in severe personality disorders, and hatred, in turn, may take the forms of conscious or unconscious envy or of an inordinate need for revenge that will color the corresponding transference developments. Similarly, regarding the sexual response, the psychoanalytic understanding of the internalized object relations activated in sexual fantasy and experience facilitates the diagnosis and treatment of abnormal condensations of sexual excitement and hatred such as those found in the perversions or paraphilias and the inhibitions of sexuality and restrictions on sexual responsiveness derived from the absorption of sexuality into the patient's conflicts concerning internalized object relations.

The unconscious identification of the patient with the role of victim and victimizer in cases of severe trauma and physical and sexual abuse can also be better diagnosed, understood, and worked through in transference and countertransference in light of the theory of internalized object relations that underlies this classification. And the understanding of the structural determinants of pathological narcissism, particularly the psychopathology of the pathological grandiose self, permits us to apply therapeutic approaches to resolve the apparent incapacity of narcissistic patients to develop differentiated transference reactions, in parallel to their severe distortions of object relations in general.

Psychoanalytic exploration has been central in providing knowledge about the characteristics of the personality disorders. In addition to further refinements in the diagnosis of the personality disorders and in therapeutic approaches in particular, psychoanalysis has the important task of investigating the relations between the findings of psychoanalytic explorations and those of the related fields of developmental psychology, clinical psychiatry, affect theory, and neurobiology.

PSYCHOANALYSIS AND PSYCHOANALYTIC PSYCHOTHERAPY OF PERSONALITY DISORDERS

In what follows I present an overview of the application of my ego psychology–object relations theory to the psychoanalysis and psychoanalytic psychotherapy of the personality disorders.

The analysis of the transference is a major concern in my general technical approach. Transference analysis consists in analyzing the reactivations of past internalized object relations in the here and now. At the same time, the component structures of ego and id and their intra- and interstructural conflicts are analyzed. I conceive of internalized object relations as reflecting a combination

of realistic and fantasied—often highly distorted—internalizations of past object relations and defenses against them under the effects of instinctual drive derivatives. In other words, I see a dynamic tension between the here and now, which reflects intrapsychic structure, and the “there and then,” unconscious psychogenetic determinants derived from the patient’s developmental history.

The basic contribution of object relations theory to the analysis of the transference is to expand the frame of reference within which transference manifestations are explored so that the increasing complexities of transference regression in patients with deep levels of psychopathology may be understood and interpreted. The nature of transference interpretation depends on the nature of the patient’s psychopathology. In practice, the transference of patients with a neurotic personality organization can be understood as the unconscious repetition in the here and now of pathogenic relations from the past—more concretely, the enactment of an aspect of the patient’s unconscious infantile self in relating to (also unconscious) infantile representations of the parental objects.

Patients with neurotic personality organization present well-integrated super-ego, ego, and id structures. In the psychoanalytic situation, the analysis of resistances brings about the activation in the transference, first, of relatively global characteristics of these structures and, later, of the internalized object relations of which these are composed. The analysis of drive derivatives occurs in the context of the analysis of the relation of the patient’s infantile self to significant parental objects as projected onto the therapist.

The fact that neurotic patients regress to a relatively integrated though repressed unconscious infantile self that relates to relatively integrated though unconscious representations of the parental objects makes such transferences fairly easy to understand and to interpret. The unconscious aspect of the infantile self carries with it a concrete wish reflecting a drive derivative directed to parental objects and a fantasied fear about the dangers involved in expressing this wish. What ego psychology—object relations theory stresses is that even in these comparatively “simple” transference enactments, the activation is always of basic dyadic units of a self-representation and an object representation linked by a certain affect, and these units reflect either the defensive or the impulsive aspects of the conflict. More precisely, an unconscious fantasy that reflects an impulse-defense organization is typically activated first in the form of the object relation representing the defensive side of the conflict and only later by the object relation reflecting the impulsive side of the conflict (O. Kernberg 1976, 1980, 1984).

What makes the analysis of internalized object relations in the transference

of patients with severe personality disorders more complex (but also permits the clarification of such complexity) is the defensive primitive splitting of internalized object relations (O. Kernberg 1975, 1992a). In these patients, the tolerance of ambivalence characteristic of higher-level neurotic object relations is replaced by a defensive disintegration of the representations of self and objects into libidinally and aggressively invested part-object relations. The more realistic or more easily understandable past object relations of neurotic personality organization are replaced by highly unrealistic, sharply idealized, or sharply aggressivized or persecutory self- and object representations that cannot be traced immediately to actual or fantasied relations of the past.

This process activates either highly idealized part-object relations under the impact of intense, diffuse, overwhelming affect states of an ecstatic nature, or equally intense but painful and frightening primitive affect states that signal the activation of aggressive or persecutory relations between self and object. We can recognize the nonintegrated nature of the internalized object relations by the patient's disposition toward rapid reversals of the enactment of the role of self- and object representations. The patient may simultaneously project a complementary self- or object representation onto the therapist; this, together with intense affect activation, leads to apparently chaotic transference developments. These rapid oscillations, as well as the sharp dissociation between loving and hating aspects of the relation to the same object, may be further complicated by defensive condensations of several object relations under the impact of the same primitive affect, so that, for example, combined father-mother images confusingly condense the aggressively perceived aspects of the father and the mother. Idealized or devalued aspects of the self similarly condense various levels of past experiences.

An object relations frame of reference permits the therapist to understand and organize what looks like complete chaos so that he can clarify the various condensed part-object relations in the transference, bringing about an integration of self- and object representations, which leads to the more advanced neurotic type of transference.

The general objectives of transference interpretation in the treatment of borderline personality organization include the following tasks (O. Kernberg 1984): (1) diagnosing the dominant object relation within the overall chaotic transference situation; (2) clarifying which is the self-representation and which the object representation of this internalized object relation and the dominant affect linking them; and (3) interpretively connecting this primitive dominant object relation with its split-off opposite.

A patient with borderline personality organization shows a predominance of preoedipal conflicts and psychic representations of preoedipal conflicts condensed with representations of the oedipal phase. Conflicts are not so much repressed as expressed in mutually dissociated ego states reflecting the primitive defense of splitting. The activation of primitive object relations that predate the consolidation of ego, superego, and id is manifest in the transference as apparently chaotic affect states; these, as noted above, have to be analyzed in sequential steps. Interpretation of the primitive transferences of borderline patients brings about a transformation of part-object relations into total object relations, of primitive transferences (largely reflecting stages of development that predate object constancy) into the advanced transferences of the oedipal phase.

At severe levels of psychopathology, splitting mechanisms permit the contradictory aspects of intrapsychic conflicts to remain at least partially conscious in the form of primitive transferences. Patients with neurotic personality organization, in contrast, present impulse-defense configurations that contain specific unconscious wishes reflecting sexual and aggressive drive derivatives embedded in unconscious fantasies relating to the oedipal objects. In these patients we find relatively less distortion of both the self-representations relating to these objects and the representations of the oedipal objects themselves. Therefore the difference between past pathogenic experiences and their transformation into currently structured unconscious dispositions is not as great as in the primitive transferences of patients with borderline personality organization.

I assume that in all cases the transference is dynamically unconscious in the sense that, because of either repression or splitting, the patient unconsciously distorts the current experience owing to his fixation to past pathogenic conflicts with a significant internalized object. The major task is to bring the unconscious transference's meanings in the here and now into full consciousness by means of interpretation. This is the first stage in analyzing the relation between the unconscious present and the unconscious past.

What is enacted in the transference is never a simple repetition of the patient's actual experiences. I agree with Melanie Klein's (1952) proposal that the transference derives from a combination of real and fantasied experiences of the past and defenses against both. This is another way of saying that the relation between psychic reality and objective reality always remains ambiguous: The more severe the patient's psychopathology and the more distorted his intrapsychic structural organization, the more indirect is the relation of current structure, genetic reconstruction, and developmental origins.