

# Aggression in Personality Disorders and Perversions, by O. Kernberg

## a. Quotes:

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## b. General Notes:

### ▪ Chapter 1 - New Perspectives on Drive Theory (pg. 3)

- "While Freud described biological sources of the sexual drives according to the excitability of the erotogenic zones, he did not describe such specific and concrete biological sources for aggression. In contrast to the fixed sources of libido, he characterized the aims and objects of both libidinal and aggressive drives as changing throughout psychic development; he described continuity of sexual and aggressive motivations in a broad variety of complex psychic developments. As Holder (1970) has pointed out, Freud clearly differentiated drives from instincts. He saw the drives as supraordinate; they were constant rather than intermittent sources of motivation. Instincts, on the other hand, were biological, inherited, and intermittent in that they were activated by physiological and/or environmental stimulation. Libido is a drive; hunger is an instinct. Freud conceived of drives as on the boundary between the physical and the mental, as psychic processes rooted in biology; he proposed (1915b, 1915c) that the only way we can know about drives is through their psychic representatives - ideas and affects." (pg. 4)
- "In my view, affects are instinctive structures—that is, biologically given, developmentally activated psychophysiological patterns. It is the psychic aspect of the patterns that becomes organized to constitute the aggressive and libidinal drives Freud described. The partial sexual drives, in this view, are more limited, restricted integrations of corresponding affect states, and libido as a drive is the hierarchically supraordinate integration of them - that is, the integration of all erotically centered affect states. In contrast to the still quite prevalent view within psychoanalysis of affects as merely discharge processes, **I consider them to be the bridging structures between biological instincts and psychic drives.** Supporting arguments for this conclusion will follow further elaboration of my definitions of affects and emotions." (pg. 5)
  - "...I define affects as psycho-physiological behavior patterns that include a specific cognitive appraisal, a specific facial pattern, a subjective experience of a pleasurable and rewarding or painful and aversive nature, and a muscular and neurovegetative discharge pattern. The expressive facial pattern is part of the general communicative pattern that differentiates each particular affect." (pg. 5)
- "I see affects as either primitive or derived. Primitive affects make their appearance within the first two or three years of life and have an intense, global quality and a diffuse, not well-differentiated cognitive element. Derived affects are more complex, consisting of combinations of the primitive affects, cognitively elaborated. Unlike primitive affects, they may not display all their original components with equal strength, and their psychic aspects gradually come to dominate the psychophysiological and facial communicative ones. For these more complex phenomena I would reserve the term emotions or feelings. This distinction corresponds to the clinical observations regarding primitive affect states and complex emotional developments in the psychoanalytic situation." (pg. 6)
- "I propose that early affect development is based on a direct fixation of early, affectively imbued object relations in the form of affective memory. Indeed, the works of Emde, Izard, and Stern all point to the central function of object relations in activating affects. Different affect states toward the same object are activated under the dominance of various developmental tasks and biologically activated instinctive behavior patterns. The variety of affect states directed to the same object may provide an economic explanation for how affects are linked and transformed into a supraordinate motivational series, which becomes the sexual or aggressive drive. For example, the pleasurable oral stimulations during nursing and the pleasurable anal stimulation during toilet training may bring about a condensed memory of pleasurable interactions with mother, linking oral and anal libidinal developments. In contrast, enraged reaction to frustrations during the oral period and power struggles during the anal period may link consonant aggressive affect states, thus integrating the aggressive drive. Further, the infant's intense positive affective investment of mother during the practicing stage of separation-individuation may later link up with a sexually imbued longing for her derived from the activation of genital feelings in the oedipal stage of development. In general, the affects of sexual excitement and rage may be considered, respectively, as the central organizing affects of libido and aggression. If we consider affects the primary psychobiological building blocks of drives and the earliest motivational systems, we still have to explain how affects become organized into supraordinate hierarchical drive systems. Why not say that the primary affects themselves are the motivational systems? In my view, a multitude of complex secondary combinations and transformations of affects exists, so that a theory of motivation based on affects rather than on two basic drives would be complex and clinically unsatisfactory. I also believe that the unconscious organization and integration of affectively determined early experience assumes a higher level of motivational organization than that represented by affect states per se. We need to assume a motivational organization that does justice to the complex integration of all affective developments in relation to the parental objects. An effort to replace both drive and affect theory with an attachment theory or an object relations theory that rejects the concepts of drives leads to a simplification of intrapsychic life by stressing only the positive or libidinal elements of attachment and neglecting the unconscious organization of aggression. Although in theory this should not necessarily be so, in practice those object relations theoreticians who have rejected drive theory have, in my view, also seriously neglected the motivational aspects of aggression." (pg. 8-9)
- "Affects thus can be seen as complex psychic structures indissolubly linked to the individual's cognitive appraisals of his immediate situation and containing a positive or negative valence with regard to the relation of the subject to the object of the particular experience. Affects, therefore, because of this cognitive appraisal component, have a motivational aspect." (pg. 12)
- "When intense affect states are activated in the transference, a corresponding gratifying or frustrating past object relation is recalled, together with the effort to reactivate that object relation if it was gratifying or escape from it if it was painful. This process of juxtaposition, in fact, illustrates the origin of fantasy—namely, the juxtaposition of an evoked remembered state with a future desired state in the context of a current perception that activates the desire for change. The formation of fantasy thus reflects the simultaneity of past, present, and future that is characteristic of the id, predating the awareness and acceptance of objective space-time constraints that characterize the differentiated ego (Jaques 1982). From a primordial integration of primitive affective memory linking "all-good" or "all-bad" peak-affect states stems the development of specific wishful fantasies linking self and object that characterize unconscious fantasy. Peak-affect states occur in connection with highly desirable (pleasurable) or undesirable (painful) experiences that motivate intense desires to respectively reinstate or avoid similar affective experiences. These desires, expressed as concrete unconscious wishes, constitute the motivational repertoire of the id. "Desire" expresses a more general motivational urge than "wish": we might say that unconscious desire is expressed in concrete wishes. Unconscious fantasy centers around wishes that concretely express desire and ultimately the drives. Peak-affect experiences may facilitate the internalization of primitive object relations organized along the axis of rewarding, or all-good, or aversive, or all-bad, ones. In other words, the experience of self and object when the infant is in a peak-affect state acquires an intensity that facilitates the laying down of affective memory structures. Originally, in these internalizations, self and object representations are not yet differentiated from each other. Fused, undifferentiated, or condensed all-good self and object representations are built up separately from equally fused, undifferentiated, or condensed all-bad self and object representations. These earliest intrapsychic structures of the symbiotic stage of development (Mahler and Furer 1968) would correspond both to the beginning of structure formation of internalized object relations and to the beginning of overall organization of libidinal and aggressive drives. At the same time, the internalization of object relations represents the origin of the tripartite structure as well: internalized object relations and their corresponding affective investment constitute the substructure of the ego, the id,

- and the superego. I see the structural characteristics associated with the id as based on a combination of several factors: the primitive, diffuse, and overwhelming nature of early affective memory derived from peak affects and the corresponding internalized object relations; the undifferentiated quality of early subjectivity and early consciousness; and the rudimentary nature of symbolic functions in the process of condensation of past, present, and evoked "future" in early fantasy formation. Affect states may have very different developmental consequences. Modulated affect states may contribute directly to ego development. Parallel mother-infant interaction and learning under conditions of mild or modulated affect states might set up memory structures reflecting more discriminatory and instrumental relations to the immediate psychosocial environment." (pg. 13-14)
- "Insofar as the earliest pleasurable peak-affect experiences of an undifferentiated self and object representation under the condition of an all-good object relation may be considered a core self experience, the awareness of self and of others is intimately linked in the area of self experience that will be incorporated into ego functions and structure as well. Although affectively modulated experiences may foster the mapping out of areas of differentiation between self and objects from early on, a core of fused or undifferentiated primitive experiences is rooted in the early ego as well as in the id. Peak-affect experiences thus give birth to a core structure of intersubjectivity, both in the earliest identification with an object of love (an "introjective identification") and in the earliest identification with an object of hatred at the "periphery" of self experience (a "projective identification"), which is later dissociated, projected more effectively, and eventually repressed. Intersubjectivity, whether incorporated in the self experience or rejected by projective mechanisms, is therefore an inseparable aspect of the development of normal identity. The psychoanalyst, too, by means of "concordant identification" —that is, empathy with the patient's central subjective experience - and "complementary identification" - that is, empathy with what the patient cannot tolerate within himself and activates by means of projective identification—may diagnose the patient's world of internalized object relations, which is part of his ego identity. The subjective experience of the self, with its component aspects of self-awareness or self-reflection, its sense of subjective continuity cross-sectionally and longitudinally, and its sense of responsibility for its actions, is more than a subjective fantasy. It constitutes an intrapsychic structure, a dynamically determined, internally consistent, stable frame for organizing psychic experience and behavioral control. It is a channel for various psychic functions that actualizes itself in these functions, a substructure of the ego that gradually acquires supraordinate functions within the ego. It represents an intrapsychic structure of the highest order, whose nature is confirmed by its behavioral consequences, its expression in character formations, and its human depth and moral commitment in relations with others. Defenses push the dynamic unconscious deeper and deeper into the psychic apparatus, a development that culminates with the establishment of repressive barriers that simultaneously signify the mutual rejection and the consolidation of the id and the ego. The dynamic unconscious of the neurotic patient and of the normal person is the end-product of a long evolution of psychic functioning, within which the qualities of consciousness and the dynamic unconscious are more closely interwoven than one might think on the basis of observation. But the eruption of the dynamic unconscious into consciousness is not reserved to patients with severe character pathology or psychoses. Interpersonal behavior in small unstructured groups, and to an even greater extent in large unstructured groups that temporarily eliminate or blur ordinary social role functions, may activate, sometimes in frightening ways, primitive contents of the repressed in the form of fantasies and behaviors shared by the entire group. This leads to the question of the ultimate nature of the motivational forces of the dynamic unconscious and to the psychoanalytic theory of drives." (pg. 18-19)
  - "In my view, **affects are the primary motivational system in that they are at the center of each of the infinite number of gratifying and frustrating concrete experiences the infant has with his environment. Affects link the series of undifferentiated self/object representations so that gradually a complex world of internalized object relations, some pleasurable tinged, others unpleasurably tinged, is constructed.** But even while affects are linking internalized object relations in two parallel series of gratifying and frustrating experiences, "good" and "bad" internalized object relations are themselves being transformed. The predominant affect of love or hate of the two series of internalized object relations is enriched and modulated and becomes increasingly complex. Eventually, the internal relation of the infant to the mother under the sign of "love" is more than the sum of a finite number of concrete loving affect states. The same holds true for hate. Love and hate thus become stable intrapsychic structures in the sense of two dynamically determined, internally consistent, stable frames for organizing psychic experience and behavioral control in genetic continuity through various developmental stages. By that very continuity, they consolidate into libido and aggression. Libido and aggression, in turn, become hierarchically supraordinate motivational systems, expressed in a multitude of differentiated affect dispositions under different circumstances. **Affects are the building blocks, or constituents, of drives; they eventually acquire a signal function for the activation of drives.** Again, it needs to be stressed that drives are manifest not simply by affects but by the activation of a specific object relation, which includes an affect and in which the drive is represented by a specific desire or wish. Unconscious fantasy, the most important being oedipal in nature, includes a specific wish directed toward an object. The wish derives from the drive and is more precise than the affect state—an additional reason for rejecting a concept that would make affects rather than drives the hierarchically supraordinate motivational system." (pg. 19-20)
  - Chapter 2 - The Psychopathology of Hatred (pg. 21)
    - "I am referring to hatred, the core affect of severe psychopathological conditions, particularly severe personality disorders, perversions, and functional psychoses. Hatred derives from rage, the primary affect around which the drive of aggression clusters; in severe psychopathology, hatred may evolve into an overwhelming dominance directed against the self as well as against others. It is a complex affect that may become the major component of the aggressive drive, overshadowing other universally present aggressive affects such as envy or disgust." (pg. 21)
    - "Clinically, the intensity of the aggressive affects - whether irritation, anger, or rage - correlates roughly with their psychological function: to assert autonomy, to eliminate an obstacle or barrier to a desired degree of satisfaction, or to eliminate or destroy a source of profound pain or frustration. But the psychopathology of aggression is not limited to the intensity and frequency of rage attacks. The most severe and dominant of the affects that together constitute aggression as a drive is the complex or elaborated affect of hatred" (pg. 22-23)
    - "Hatred is a complex aggressive affect. In contrast to the acuteness of rage reactions and the easily varying cognitive aspects of anger and rage, the cognitive aspect of hatred is chronic and stable. Hatred also presents with characterological anchoring that includes powerful rationalizations and corresponding distortions of ego and superego functioning. **The primary aim of one consumed by hatred is to destroy its object, a specific object of unconscious fantasy, and this object's conscious derivatives; the object is at bottom both needed and desired, and its destruction is equally needed and desired.** Understanding this paradox is at the center of the psychoanalytic investigation of this affect. Hatred is not always pathological: as a response to an objective, real danger of physical or psychological destruction, a threat to the survival of oneself and those one loves, hatred is a normal elaboration of rage aimed to eliminate that danger. But unconscious motivations usually enter and intensify hatred, as in the search for revenge. When it is a chronic characterological predisposition, hatred always reflects the psychopathology of aggression. An extreme form of hatred demands the physical elimination of the object and may be expressed in murder or in a radical devaluation of the object that may generalize in the form of a symbolic destruction of all objects - that is, all potential relationships with significant others— as is clinically observable in antisocial personality structures. This form of hatred is sometimes expressed in suicide, where the self is identified with the hated object and self-elimination is the only way to destroy the object as well. Clinically, some patients with the syndrome of malignant narcissism (narcissistic personality, ego-syntonic aggression, paranoid and antisocial tendencies) and "psychopathic" transferences (deceptiveness as a dominant transference feature may consistently attempt to exploit, destroy, symbolically castrate, or dehumanize significant others— including the therapist—to an extent that defies the therapist's efforts to protect or recapture some island of an idealized primitive, all-good object relationship. At the same time, the transference may appear to be remarkably free from overt aggression; chronic deceptiveness and the search for a primitive all-good self state that eliminates all objects—by means of alcohol or drugs, for example, and by unconscious and conscious efforts to coopt the therapist in the exploitation or destruction of others-dominate the scene." (pg. 23-24)

- "A less severe degree of hatred is expressed in sadistic tendencies and wishes; the patient has an unconscious or conscious desire to make the object suffer, with a sense of profound conscious or unconscious enjoyment of that suffering. Sadism may take the form of a sexual perversion with actual physical damaging of the object, or it may be part of the syndrome of malignant narcissism, sadomasochistic personality structure, or, sometimes, a rationalized, intellectualized form of cruelty that includes wishes to humiliate the object. In contrast to the earlier, more encompassing form of hatred, sadism is characterized by the wish not to eliminate but to maintain the relationship with the hated object in an enactment of an object relationship between a sadistic agent and a paralyzed victim. The desire to inflict pain and pleasure in doing so are central here, representing an implicit condensation of aggression and libidinal excitement in inducing such suffering. A still milder form of hatred centers around the desire to dominate the object, a search for power over it that may include sadistic components but in which attacks on the object tend to be self-limited by the object's submission and its implied reconfirmation of the subject's freedom and autonomy. Anal-sadistic components predominate over the more primitive oral-aggressive ones found in the more severe forms of hatred; the assertion of hierarchical superiority and "territoriality" in social interactions and the aggressive aspects of regressive small- and large-group processes are the most frequent manifestations of this milder level of hatred. Finally, in those with relatively normal superego integration and a neurotic personality organization with a well-differentiated tripartite structure, hatred may take the form of a rationalized identification with a strict and punitive superego, the aggressive assertion of idiosyncratic but well-rationalized systems of morality, justified indignation, and primitive levels of commitment to vindictive ideologies. Hatred at this level, of course, bridges over to the sublimatory function of courageous aggressive assertion in the service of commitment to ideals and ethical systems. At this level of integration there is usually also a tendency toward self-directed hatred in the form of cruelty of the superego; clinically we see a potential for a transformation of transferences from the primitive "paranoid" into the more advanced "depressive" type. Masochistic and sadomasochistic personality structures and mixed neurotic constellations including paranoid, masochistic, and sadistic traits may experience relatively sudden shifts between depressive and paranoid transference regression. In contrast, at more severe levels of psychopathology, the transference is overwhelmingly paranoid, except when psychopathic transferences defend the patient against the paranoid ones. The entire spectrum of affective and characterological components of hatred may be observed in the transference of patients of the second level of pathology, patients who have at least a wish to preserve the hated object. The chronicity, stability, and characterological anchoring of hatred is matched by the desire to inflict pain upon the object, characterological—and sometimes sexual-sadism, and cruelty. Primitive hatred also takes the form of an effort to destroy the potential for a gratifying human relationship and for learning something of value in that human interaction (see chap. 13). Underlying this need to destroy reality and communication in intimate relationships is, I believe, unconscious and conscious envy of the object, particularly of an object not dominated from within by similar hatred." (pg. 24-25)
  - "It was Melanie Klein (1957) who first pointed to envy of the good object as a significant characteristic of patients with severe narcissistic psychopathology. Such envy is complicated by the patient's need to destroy his own awareness of it, lest his terror over the savagery of his hatred of what, au fond, he values in the object be exposed. Behind the envy of the object and the need to destroy and spoil anything good that might come from contacts with it lies unconscious identification with the originally hated—and needed—object. Envy may be considered both a source of a primitive form of hatred, intimately linked with oral aggression, greed, and voracity, and a complication of the hatred that derives from the fixation to trauma. At the surface, hatred of the unconsciously—and consciously - envied object is usually rationalized as fear of the object's destructive potential, deriving both from actual aggression inflicted by essentially needed objects in the patient's past (in patients who have been severely traumatized) and from projection of his own rage and hatred. Tendencies toward chronic and potentially severe self-mutilation and non-depressive suicidal behaviors frequently accompany the syndrome of malignant narcissism. Self-mutilation typically reflects unconscious identification with a hateful and hated object. Hatred and the inability to tolerate communication with the object may protect the patient from what might otherwise emerge as a combination of cruel attacks on the object, paranoid fears of that object, and self-directed aggression in identification with the object." (pg. 25-26)
- "Basically, the patient is enacting an object relation between persecutor and victim, alternating these roles in his identifications while projecting the reciprocal role onto the therapist. In the most pathological cases, it is as if the only alternative to being victimized is to become a tyrant, and the repeated assertions of hatred and sadism would appear to be the only form of survival and meaning, aside from murder, suicide, or psychopathy. In milder cases, an additional dynamic factor, envy, emerges— intolerance of the good object who escapes from that savagery and who is hated for willfully withholding (as the patient fantasizes) what could transform the object from a persecuting one into an ideal one. Here the search for an ideal object (an ideal mother) lies behind the unending onslaught of hatred in the transference." (pg. 26)
- "Intense attachment to the frustrating mother is the ultimate origin of the transformation of rage into hatred. The cause of this transformation is the fixation to a traumatic relationship with a fundamentally needed object that is experienced as all-bad and as having destroyed or swallowed up the ideal, all-good object. The revengeful destruction of this bad object is intended to magically restore the all-good one, but in the process it leads to the destruction of the very capacity of the self to relate to the object. This transformation takes the form of identifying not simply with the object (mother) but with the relationship to her, so that the hatred of mother as victimizer, with its painful, impotent, paralyzing implications, also is transformed into identification with her as the cruel, omnipotent, destructive object. At the same time a search develops for other objects onto whom the attacked, depreciated, and mistreated self can be projected. In identifying with both suffering self and sadistic object, the subject is himself swallowed up by the all-encompassing aggression in the relationship. Hatred as a reversal of suffering is a basic type of revengeful triumph over the object, a triumph also over the terrifying self representation achieved by projective identification, and symbolic revenge for past suffering condensed in the fixation to sadistic behavior patterns. Patients so motivated mistreat others sadistically because they experience themselves as being mistreated, again, by sadistic objects; unconsciously, they become their own persecutory objects while sadistically attacking their victims. They cannot escape being victim and perpetrator at the same time. As victimizer, they cannot live without their victim—the projected, disowned persecuted self; as victim, they remain attached to their persecutors internally and sometimes, in behavior shocking to an observer, externally as well. Extremely contradictory, unreliable behaviors on the part of mother probably reinforce the psychopathic end of the spectrum of hatred by permitting the interpretation of her behavior as a betrayal by the potentially good object, which thus becomes unpredictably and overwhelmingly bad. Identification with a betraying object initiates the path to a revengeful destruction of all object relations. The ultimate source of the paranoid urge to betray (Jacobson 1971a, pp. 302-318) probably lies here. The most severely psychopathological attachment behavior has been described in infants whose mothers' behavior combined abandonment, violence, chaos, and a teasing overstimulation together with chronic frustration (Fraiberg 1983; Galenson 1986)." (pg. 27-28)
- "Excessive activation of aggression as a drive (to which characterologically fixated hatred contributes fundamentally) interferes with the normal integration of the mutually dissociated, all-good and all-bad internalized object relations at the conclusion of the developmental phase of separation-individuation and therefore with the initiation of object constancy and the advanced stage of oedipal development. In disrupting these processes, excessive aggression leads to fixation at a point when all-good and all-bad internalized object relations were not integrated, while self and object representations within each of these all-good and all-bad object relationships were differentiated from each other. These constitute the psycho-structural conditions of borderline personality organization, characteristic of severe personality disorders in which preoedipal and oedipal aggression is dominant. Under more favorable circumstances, integration of all-good and all-bad internalized object relations may proceed and object constancy may develop, leading to integration of the ego and superego structures and to the establishment of repressive boundaries separating ego from id: the tripartite structure consolidates. Under such conditions the pathological hatred is absorbed by the superego. The integration of early sadistic superego

- precursors with the preoedipal ego ideal, on the one hand, and of oedipal prohibitions and demands with those earlier superego structures, on the other, leads to sadistic superego demands, depressive-masochistic psychopathology, and secondarily rationalized characterological sadism correlated with the integration of cruel and sadistic ethical systems. Or perhaps various sexual pathologies, including perversions at a neurotic level of personality organization, may contain hatred as a relatively harmless, eroticized symptom." (pg. 29)
- Chapter 3 - Clinical Dimensions of Masochism (pg. 35)
    - "The depressive-masochistic personality disorder is characterized by three particular types of character traits: (1) those reflecting an intransigent superego, (2) traits reflecting overdependency on support, love, and acceptance from others, and (3) traits reflecting difficulties in the expression of aggression. The "superego" features of the depressive-masochistic personality are reflected in a tendency to be excessively serious, conscientious, and concerned about work performance and responsibilities. These patients are highly reliable and dependable, tend to judge themselves harshly and to set extremely high standards for themselves. They are somber and may lack a sense of humor. But in contrast to their usually considerate, tactful, and concerned behavior, they may occasionally show harshness in their judgment of others, a harshness that may be tinged with justified indignation. When these patients do not live up to their own high standards and expectations, they may become depressed. They may even, when their inordinate demands on themselves are matched by their unconscious tendency to put themselves into circumstances that will induce suffering or exploitation, unconsciously create or perpetuate an external reality that will justify their sense of being mistreated, demeaned, or humiliated. The traits that reflect overdependency on support, love, and acceptance from others also reveal, on psychoanalytic exploration, a tendency to feel inordinately guilty toward others because of unconscious ambivalence toward loved and needed objects and to overreact to frustration when these patients' expectations are not met. They show an abnormal vulnerability to being disappointed by others, often going far out of their way to obtain sympathy and love. In contrast to the narcissistic personality, who is overdependent on external admiration but does not respond with love and gratitude, the depressive-masochistic personality typically is able to respond deeply with love and to be grateful. The sense of being rejected and mistreated in reaction to relatively minor slights may lead these patients to unconscious behaviors geared to making the objects of their love feel guilty. A chain reaction is set up of heightened demandingness, feelings of rejection, and an unconscious tendency to try to make others feel guilty; consequent actual rejection from others may spiral into severe problems in intimate relations and may also trigger depression connected to loss of love." (pg. 37)
    - **"Sadomasochistic personalities usually present borderline personality organization with identity diffusion, nonspecific manifestations of ego weakness (lack of anxiety tolerance, impulse control, and sublimatory channeling), predominance of part-object relations, and prevalence of primitive defensive mechanisms (splitting, projective identification, denial, primitive idealization, omnipotent control, and devaluation).** Within the chaos of their object relations, the intensification of chaotic interactions with their closest intimates stands out. These patients usually experience themselves as the victims of others' aggression, bitterly complain about being mistreated, and adamantly justify their own aggressions toward those upon whom they are dependent. The "help-rejecting complainer" (Frank et al. 1952) is typical, these patients' interpersonal and social difficulties may lead to chronic failure at work and socially as well as in intimate relations. In contrast to the impulsive, chaotic, arrogant, and devaluating behaviors of the narcissistic personality functioning on an overt borderline level, the sadomasochistic personality has much more capacity for investment in depth in relations with others; he is dependent and clinging, unlike the aloof narcissistic personality. The dynamic features of these patients include severe conflicts, both oedipal and preoedipal, particularly an internal dependency on primitive maternal images experienced as sadistic, dishonest, and controlling; such images exacerbate oedipal fears and condense unconscious oedipal and preoedipal issues in these patients' behaviors much more than occurs with preoedipal regression of patients with depressive-masochistic personality and essentially oedipal dynamics. One male patient experienced intense feelings of insecurity and inferiority toward his analyst while berating him continually. In his relationships with girlfriends, he was both extremely afraid that they would drop him for more attractive men and extremely demanding of their time and attention; his breakups with girlfriends were followed by pathological mourning with intense paranoid reactions, alternating with a depressive sense of having been abandoned. The lack of integration of superego functions, the projection of primitive superego precursors in the form of paranoid traits, and the tolerance of contradictory behaviors - in fact, the rationalization of aggressive behaviors - all illustrate the failure of superego functions to integrate in these patients, in marked contrast to the rigid superego integration of the depressive-masochistic personality disorder." (pg. 38-39)
  - Chapter 4 - Hysterical and Histrionic Personality Disorders (pg. 52)
    - See text
  - Chapter 5 - Antisocial and Narcissistic Personality Disorders (pg. 67)
    - "In essence, I propose that all patients with an antisocial personality disorder present features typical of the narcissistic personality disorder plus a specific pathology of their internalized systems of morality (their superego functions) and a particular deterioration of their world of internalized object relations. The only significant exception to this rule is the relatively infrequent and prognostically grave clinical syndrome of "pseudo-psychopathic schizophrenia" typically found in chronic schizophrenic patients with periodic improvement (with or without treatment) and antisocial behavior during such periods of "improvement," which disappears only when the patient again becomes psychotic. There is also a group of patients who stand somewhere between the narcissistic personality disorder and the antisocial personality disorder, characterized by what I have called the syndrome of malignant narcissism (1984). This syndrome is defined by the combination of (1) a narcissistic personality disorder, (2) antisocial behavior, (3) ego-syntonic aggression or sadism directed against others or expressed in a particular type of triumphant self-mutilation or attempts at suicide, and (4) a strong paranoid orientation." (pg. 67)
    - **"The typical symptoms of the narcissistic personality in the area of pathological self-love are excessive self-reference and self-centeredness; grandiosity and the derived characteristics of exhibitionism, an attitude of superiority, recklessness, and over-ambitiousness; overdependency on admiration; emotional shallowness; and bouts of excessive insecurity alternating with grandiosity. In the area of pathological object relations, these patients' predominant symptoms are inordinate envy (both conscious and unconscious); devaluation of others as a defense against the envy; exploitativeness manifested by greediness, appropriation of others' ideas or property, and an attitude of entitlement; an incapacity to truly depend on others in a mutual relationship; and a remarkable incapacity for empathy with and commitment to others. The basic ego state of these patients is characterized by a chronic sense of emptiness, evidence of an incapacity to learn, a sense of isolation, stimulus hunger, and a diffuse sense of the meaninglessness of life.** In addition, these narcissistic patients present some degree of superego pathology, including the incapacity to experience self-reflective sadness, deep mood swings, a predominance of shame as contrasted to guilt in their intrapsychic regulation of social behavior, and a value system more childlike than adult; that is, they value physical beauty, power, wealth, and the admiration of others as against capabilities, achievements, responsibility, and relation to ideals. The antisocial personality disorder proper presents even more serious superego pathology. These patients' antisocial behavior includes lying, stealing, forgery, swindling, and prostitution—all of a predominantly "passive-parasitic" type; assault, murder, and armed robbery are characteristic of the "aggressive" type (Henderson 1939; Henderson and Gillespie 1969). In other words, one may differentiate clinically the behaviorally aggressive, sadistic, and usually also paranoid orientation of some patients with antisocial personality disorder from the passive, exploitative, parasitic type of others." (pg. 73-74)
      - "The inability to invest in nonexploitative relationships with others may be reflected in transient, superficial, indifferent relationships, inability to invest emotionally even in pets, and the absence of any internalized moral values, let alone the capacity to empathize with such values in others. The deterioration of these patients' affective experience is expressed in their intolerance of any increase in anxiety without developing additional symptoms or pathological behaviors, their incapacity for depression with reflective sorrow, and their inability to fall in love or experience any tenderness in their sexual relations. These patients have no sense of the passage of time, of planning for the future, of

- contrasting present experience and behavior with aspired ideal ones; they can plan only to improve present discomforts and reduce tension by achieving immediately desired goals. Their failure to learn from experience is an expression of the same incapacity to conceive of their life beyond the immediate moment. Their manipulateness, pathological lying, and flimsy rationalizations are well known. Paulina Kernberg (personal communication) has coined the term hologram man to refer to patients who create a vague, ethereal image of themselves in the diagnostic sessions that seems strangely disconnected from their current reality or their actual past, an image that changes from moment to moment in the light of different angles of inquiry and leaves the diagnostician with a disturbing sense of unreality." (pg. 75-76)
- "Again, once the diagnosis of a narcissistic personality structure is obvious, the crucial diagnostic task is to evaluate the severity of any presenting antisocial features, their past history and childhood origins, and the patient's remaining capacity for object relations and superego functioning. The virtually total absence of the capacity for nonexploitative object relations and of any moral dimension in personality functioning is the key element in differentiating the antisocial personality proper from the less severe syndromes of malignant narcissism and narcissistic personality disorder. This diagnosis may be arrived at by taking a complete history, carefully exploring the patient's narrative, tactfully confronting him with contradictory and obscure areas in this narrative, evaluating his interaction with the diagnostician, and exploring his reactions to being confronted with contradictions among objective information from his past, his current narrative, and his behavior." (pg. 76)
  - "These patients convey the impression that their world of object relations has experienced a malignant transformation, leading to the devaluation and sadistic enslavement of potentially good internalized object relations on the part of an integrated, yet cruel, omnipotent, and "mad" self (Rosenfeld 1971). This pathological grandiose and sadistic self supplants the sadistic precursors of the superego, absorbs all aggression, and transforms what would otherwise be sadistic superego components into an abnormal self-structure, which then militates against the internalization of later, more realistic superego components. These patients experience external objects as omnipotent and cruel. They feel that loving, mutually gratifying object relations not only can easily be destroyed but contain the seeds for an attack by the omnipotent, cruel object. One way to survive is by total submission. A subsequent route is to identify with the object, which gives the subject a sense of power, freedom from fear, and the feeling that the only way to relate to others is by gratifying one's aggression. An alternative route is to adopt a false, cynical way of communication, totally denying the importance of object relations, becoming an innocent bystander rather than identifying with the cruel tyrant or submitting masochistically to him." (pg. 82)
  - "This failure to achieve any idealization of objects differentiates the antisocial personality proper from the "self-righteous" aggression of the patient with malignant narcissism, who has at least found some possibility of condensing sadism and idealization by identifying himself with an idealized, cruel tyrant. The failure of idealization also prevents the antisocial patient from attempting masochistic submission to a predictable although sadistic authority. The patient is deeply and totally convinced that only his own power is reliable and that the pleasure of sadistic control is the only alternative to the suffering and destruction of the weak. In such a world, there is a need (to paraphrase Paul Parin (1971)) to "fear thy neighbor as thou fearest thyself" and to devalue all weakening linkages with others. So far, I have focused on the predominantly aggressive antisocial personality disorder. The passive-parasitic antisocial personality disorder, in contrast, has found a way out of gratification via sadistic power by denying the importance of all object relations and regressively idealizing the gratification of receptive-dependent needs - food, objects, money, sex, privileges - and the symbolic power exerted over others by extracting such gratifications from them. To get the needed supplies while ignoring others as persons and protecting oneself from revengeful punishment is the meaning of life. To eat, to defecate, to sleep, to have sex, to feel secure, to take revenge, to feel powerful, to be excited, all without being discovered by the surrounding dangerous though anonymous world - this constitutes a sort of adaptation to life, even if it is the adaptation of a wolf disguised to live among the sheep, with the real danger coming from other wolves similarly disguised, against whom the protective "sheepishness" has been erected. This psychological structure permits the denial of aggression and its transformation into ruthless exploitation. In patients with malignant narcissism, some idealized superego precursors have been drawn into the aggressively infiltrated, pathological grandiose self, facilitating at least a consolidated sense of self, of self-continuity throughout time, and, by means of projection, a sense of stability and predictability of the world of powerful and dangerous others as well. The pathological narcissism, ego-syntonic grandiosity, antisocial behavior, and paranoid alertness of these patients allow them to control their internal world of object relations. This same pathological grandiose self simultaneously protects them from the unbearable conflicts around primitive envy that torment the less protected narcissistic personality. The antisocial personality proper, in contrast, is protected from rageful envy only by aggressive, violent appropriation or passive-parasitic exploitation of others." (pg. 83)
  - Chapter 6 - Object Relations Theory in Clinical Practice (pg. 87)
    - "I believe that economic, dynamic, and structural factors provide the optimal criteria for deciding when, what, and how to interpret the patient's unconscious conflicts, their defensive and impulsive aspects, and, I would add, the unconscious internalized object relations in which they are embedded. The economic criterion for the material to be interpreted within any psychoanalytic session or any segment of a session is that the material be linked to the patient's dominant affect disposition. This disposition or affect state is not necessarily conscious and may have to be inferred from the patient's free associations, his or her nonverbal behavior, and the general atmosphere created by the confluence of the patient's transference and the analyst's countertransference. This affect state always signals the activation of an unconscious object relation between an aspect of the patient's self representation and a corresponding object representation. And the conflict between impulse and defense is reflected in a conflict between a defensively activated and an impulsively dominated, rejected internalized object relation. Unconscious fantasy, the unconscious wishes and fears activated in the session, reflects these internalized object relations. **I believe that a self representation, an object representation, and an affect state linking them are the essential units of psychic structure relevant for psychoanalytic exploration.** Sexual and aggressive drives always emerge in the context of internalized object relations organized by affect states that, at the same time, signal these (hierarchically supraordinate) drives. To put this differently, if, as Freud (1915a) said, the only knowledge we have of drives is through their mental representations and affects, these representations are of the self and an object linked by a dominant affect state." (pg. 87-88)
    - "What does an object relations approach add to these formulations regarding the transference? First, it highlights the consistent **set of dyadic units (a self representation interacting with an object representation under the dominance of a certain affect)**, and it frames the experience of concrete unconscious fantasies, wishes, and fears. Second, it sees each defense-impulse organization as reflected in two opposed units, so that both defense and impulse are reflected in a fantasied relation between self and object. Third, even at the neurotic level of pathology, a process may be observed that becomes prevalent with deeper psychopathology: the rapid reversal or alternation between the activation of the patient's self representation with the object representation projected onto the analyst and other moments when the patient enacts an identification with that object representation while projecting the self representation onto the analyst." (pg. 91-92)
    - "In thus examining afresh the nature of identifications in the transference, **I am suggesting that all identifications are with a relation to an object, not with an object.** I am further suggesting that in the relation the patient identifies with both self and object, with the possibility of reenacting the roles of either. I believe this conceptualization throws new light on Freud's (1915a) observation that an instinct may undergo, among other things, the vicissitudes of reversal into its opposite and finding the object in the subject's self. Freud also emphasized that mental life generally is governed by dichotomies - of subject (ego and object external world), of pleasure and unpleasure, of active and passive. In the light of object relations theory, the expression of an "active" impulse - aggression, for example - that was first experienced passively may be understood as either the activation of a self representation under a subjectively experienced attack from the object or as the activation of an identification with the object representation of that interaction. "Identification with the aggressor," also illustrated in my example and now conceptualized as a consequence of identifying with both self

- and object, exemplifies the transformation of passive into active impulse expression." (pg. 92)
- Chapter 7 - An Ego Psychology - Object Relations Theory Approach to the Transference (pg. 103)
    - "Transference analysis consists in analyzing the reactivations in the here-and-now of past internalized object relations. This process constitutes, at the same time, the analysis of the constituent structures of ego, super-ego, and id and their intra- and interstructural conflicts. In contrast to the interpersonal object relations theoreticians such as Sullivan (1953, 1962) and Guntrip (1961, 1968, 1971), and in contrast to Kohut's (1971, 1977) self psychology, **I conceive of internalized object relations as reflecting not actual object relations from the past but rather a combination of realistic and fantasied—and often highly distorted— internalizations of such 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 genetic determinants derived from the patient's past developmental history." (pg. 103)
  - Chapter 8 - An Ego Psychology - Object Relations Theory of Structural Change (pg. 119)
    - See text
  - Chapter 9 - Transference Regression and Psychoanalytic Technique (pg. 140)
    - "**Patients with an infantile personality present the three characteristics dominant in all borderline patients: identity diffusion, primitive defense mechanisms, and good reality testing.** Identity diffusion reduces their capacity for empathy with others and for realistic evaluation and prediction of their own and other people's behavior. In consequence, they present highly conflictual object relations, although they can engage in depth in the sense of lasting - though chaotic and clinging - relations with significant others. This capacity for deep involvement with others, even if highly neurotic in nature, differentiates them from other **patients with borderline personality organization, such as the narcissistic, schizoid, and paranoid personalities.** Because **these patients present a predominance of defensive operations centering around splitting, they evince fewer repressive mechanisms than are typical of the hysterical personality proper.** Thus, the latter's sexual inhibition may be replaced by the persistence of polymorphous perverse infantile trends, even in patients who definitely do not present evidence of sexual perversion. **Splitting operations underlie these patients' contradictory, discontinuous, chaotic interpersonal behavior.** Infantile personalities present the emotional lability and histrionic quality characteristic of hysterical patients, but in all their object relations rather than specifically linked to their sexual relationships. They also show the extroverted, exhibitionistic behavior of the hysterical personality, except that their behavior has a childlike, clinging, rather than erotic quality. Infantile patients convey the impression that erotic seductiveness is a means to gratify clinging and dependent rather than sexual needs. From a psychodynamic viewpoint, infantile patients present the typical condensation of oedipal and preoedipal conflicts characteristic of borderline personality organization, but with an accentuation of later or advanced types of oedipal conflicts, which brings them much closer to the hysterical personality than is true of all other borderline patients. One might indeed describe a continuum from the hysterical personality proper to the infantile personality proper, a point of view already implicit in Zetzel's (1968) classification of this syndrome into four types (see chap. 4). In light of my more recent experience, most of these patients can be treated with psychoanalysis; thus they constitute, together with the narcissistic personality, the important exceptions to the dictum that psychoanalysis is not appropriate for patients with borderline personality organization. In order for psychoanalysis to be indicated for an infantile personality, however, it is important that the patient present at least some motivation for treatment, some capacity for emotional introspection or insight, and for impulse control, anxiety tolerance, and sublimatory functioning (nonspecific aspects of ego strength). These requirements exclude from consideration for psychoanalysis the typical Zetzel type 4 patient, with nonspecific manifestations of ego weakness, apparently uncontrollable acting out, and limited capacity for realistic self-reflection." (pg. 140-141)
  - Chapter 10 - Projection and Projective Identification (pg. 159)
    - "**Projective identification is a primitive defense mechanism. The subject projects an intolerable intrapsychic experience onto an object, maintains empathy (in the sense of emotional awareness) with what he projects, tries to control the object in a continuing effort to defend against the intolerable experience, and unconsciously, in actual interaction with the object, leads the object to experience what has been projected onto him. Projection itself, a more mature form of defense, consists of first repressing the intolerable experience, then projecting it onto the object, and finally, separating or distancing oneself from the object to fortify the defensive effort.**" (pg. 159)
    - "Elsewhere (chap. 2) I describe how patients with psychotic object relations use projective identification in a desperate attempt to prevent themselves from lapsing into utter confusion regarding the differentiation of self and object. Under such circumstances, projective identification may permit a patient to localize aggression outside the self. In contrast, a person with borderline pathology uses projective identification to maintain splitting of all-good from all-bad ego states. Projective identification is thus not necessarily based upon lack of differentiation between self and object representations (although it may occur under such conditions), nor does it necessarily cause a loss of differentiation between self and object representations, although it weakens reality testing temporarily in borderline patients. My concept of projective identification is supported by my clinical observations of the effects of interpreting this defense mechanism to a patient. The psychotic patient will be temporarily more confused and his reality testing will be diminished; the borderline patient will respond by an improvement in reality testing, even if only temporarily. Projective identification, then, is a primitive defensive operation but is not necessarily linked to psychosis. It predominates in the psychoses, where it is accompanied by loss of reality testing and, from a structural viewpoint, by the loss of boundaries between self and object representations. In borderline personality organization, projective identification is accompanied by maintenance of reality testing, structurally underpinned by differentiation of self from object representations, and permits the utilization of particular therapeutic techniques to deal with it interpretively, with the result of strengthening reality testing and the patient's ego. Projective identification plays a relatively unimportant role in the neuroses (except when the patient undergoes severe temporary regression) and is for the most part replaced by projection." (pg. 160-161)
    - "**I propose that a developmental line of defenses leads from projective identification, which is based on an ego structure centered upon splitting (primitive dissociation) as its essential defense, to projection, which is based on an ego structure centered upon repression as a basic defense.** Generally, I believe, it is possible to trace a developmental line for other types of defensive operations. For example, we see a developmental line from primitive idealization, in which the splitting is between idealized and persecutory objects, to the idealization typical of the narcissistic personality (in which self-idealization, either ego-syntonic or projected, is the counterpart of devaluation), to the idealization typical of neurotic personality organization which reflects reaction formations against guilt, and finally, to normal idealization as part of the externalization of integrated aspects of the ego ideal. (Normal idealization, for example, plays an important role in falling in love.) Again, denial as defined by Jacobson (1957a), which is based on primitive dissociation of contradictory ego states, may be seen as the primitive form of negation, a more advanced mechanism based on repression and a typically neurotic defensive operation. In a different defense area, primitive introjection (when the subject lacks the capacity to differentiate self from object representations) may be seen as the precursor of introjections that occur in connection with identifications characteristic of advanced stages of ego and superego development. In short, **whether splitting or repression is prevalent as a central means of defense determines whether projective identification or projection predominates.** If projective identification implies that the subject has the capacity to differentiate self from non-self, it can be assumed that the subject must have reached a certain level of development before projective identification is operational. I assume two conditions that must be fulfilled. Insofar as projective identification implies a fantasy—and in order to fantasize we have to assume the capacity for having one element stand for another and be manipulated in the direction of a desired goal—the capacity for symbolization must be present. And insofar as the wish is to expel onto another what is felt as undesirable, there must exist a capacity for awareness not only of the difference between the self and the other but also of how one feels—of one's subjective state. Only when we can recognize a particular subjective state as undesirable in comparison with other subjective states does it make sense to attempt to get rid of it by expulsion. These capacities probably exist by the time the

infant is fifteen months old (Stern 1985). For reasons which I elaborate on below (see also chap. 1), I assume that the core mental representations of self and object are established when the infant is stimulated by extreme pleasure or pain rather than when he is in a quiescent and merely alert state. The effect of learning during peak-affect states differs from the effect of learning during alert quiescent states. In the latter, the infant has no wish to fuse with or separate itself from the other; hence the issue of boundaries is not present. But experiences during peak-affect states foster both fusion and differentiation. If the state is one of extreme pleasure, the infant wishes to fuse with the provider of that pleasure. If the affect state is one of extreme displeasure or pain, the infant's wish to expel the pain fosters differentiation. **Projective identification is an essential defense mechanism to deal with intolerable psychic pain during negative peak-affect states, when self-awareness and symbolization are operational. Projection, in contrast, requires the achievement of a further state of development in which a clear differentiation between representations of self and of object, and between self and external objects, is matched by a sense of continuity of self-experience under contradictory emotional circumstances.** This implies the ability to tolerate ambivalence and to experience a sense of continuity—the "categorical self" of the philosophers. Self-awareness is now not only that of temporarily changing subjective experiences but of a subjective self as something stable against which each subjective state is evaluated. **Projection may be conceived as a "healthier," more adaptive outcome of projective identification,** at least at early stages of integration of the self concept and consolidation of repressive barriers. Eventually, of course, projection has maladaptive consequences because it can result in the distortion of external reality." (pg. 161-162)

- Chapter 11 - Projective Identification, Countertransference, and Hospital Treatment (pg. 175)
  - "Perhaps most disturbing and dramatic is the corruption of moral values that typically takes place as part of the regressive processes I am describing. **Freud (1921) originally described how the members of a mob project the ego ideal onto the idealized leader. The effect is to eliminate moral constraints as well as the superego-mediated functions of self-criticism and responsibility of each of the members.** In large groups - that is, in groups of 30 to 150 people who can still communicate with each other (and thus are not yet a mob) but who do not have (at least momentarily) a functional leadership - the projection of superego functions onto the leader cannot, of course, develop (Turquet 1975; Kernberg 1980, pp. 219-220; Anzieu 1985). What obtains instead is a projection of primitive superego functions onto the group itself. Instead of projecting the mature superego functions of each individual member onto the group at large, the large-group members tend to project a minimal, highly conventional morality onto the group. The rigidity and lack of discriminating characteristics of this conventional morality create a generalized fear of "how others may react," while the individual members of these groups are strangely "liberated" from their ordinary, mature superego functions and tend to attempt to "get away with what they can." The combination of a diffuse conventionality and a reduced individual sense of responsibility creates the preconditions for a general corruption of the adherence to moral values within this group setting. This is the background against which the self-indulgent group ideology fostered by a narcissistic leader and the rationalization of aggression facilitated by a paranoid leader reinforce the moral corruptibility of regressive large groups. Zinoviev (1984) described the characteristics of groups whose egalitarian ideology fosters the projection of moral authority onto the group at large and finally, to protect their egalitarianism, onto external "persecutory" authority figures. He described the prevalence, under such conditions, of careerism, selfishness, and neglect of functional tasks, the enjoyment of others' failures, a tendency to gang up against those who get ahead, a search for propitiatory victims, and a search for an authoritarian leader to mediate the threatening conflicts within the group. Such groups also show a negative attitude toward individuality, the differentiation of individuals, and courage. This description, derived from the study of the egalitarian structure of group processes in factories, schools, and other social organizations in the Soviet Union, dramatically replicates the studies of the psychology of large-group processes carried out in experimental settings by Rice (1965), Turquet 1975), and Anzieu (1984). My point is that, given the great potential for activation of superego corruption in the large group under regressive conditions, a dramatic and dangerous potential exists for the replication in the hospital's social system of patients' specific superego pathology as well. Projective identification, then, is a powerful primitive defensive operation that may induce intense countertransference reactions in the therapist in the form of complementary identification and, simultaneously, regressive group processes in the hospital setting by directly triggering latent conflicts in the hospital's social system. The therapist's leadership functions for the large group thus activated create the condition of mutual reinforcement of the patient's pathology, the group's pathology, and the therapist's countertransference, leading under the worst circumstances to an uncanny replication within the social system of the patient's social, familial, and intrapsychic pathology. When this pathology includes significant superego deterioration, a potential corruption of the social system of the hospital may replicate and amplify the corresponding aspects of the patient's intrapsychic pathology." (pg. 190-192)
- Chapter 12 - Identification and its Vicissitudes (pg. 193)
  - "I use internalization as an umbrella concept to refer to the building up of intrapsychic structures that result from both actual and fantasied interactions with significant objects under the impact of drive derivatives represented by specific affect states. The basic unit of internalization, as I see it, is dyadic, consisting of a self and an object representation in the context of a specific affect representing libidinal and/or aggressive drives. I conceive of introjection, identification, and identity formation as developmentally progressive levels of internalization. Introjection, the most primitive of these, occurs during the symbiotic stage of development (Mahler and Furer 1968; Mahler et al. 1975), when self and object representations are not yet differentiated from each other; identification takes place when self and object representations have been differentiated from each other - that is, in the stage of separation-individuation. Identity formation refers to the more general intrapsychic process of integration of libidinally and aggressively invested self representations into a cohesive self, in parallel to the simultaneous integration of libidinally and aggressively invested object representations into broader representations of significant objects. Ego identity is the result of this process. It includes both a longitudinal temporal and a cross-sectional integration of the self. Identifications are normally partial or selective: they imply modification of the self concept under the influence of the object. At the same time, an increase in differentiation between self and object is implied in the discrimination among aspects of the object that are and are not incorporated. Identifications thus have progressive or growth-promoting functions. Identification that normally takes place during development can be contrasted with psychotic identification, a pathological process that may take place at any time in the context of the development of a psychotic process. Psychotic identifications reflect a defensive regression to aspects of the symbiotic stage of development. They are characterized by the internalization of an object relation that is defensively refused, including the refusal of all-good self and object representations under the dominance of real or fantasied gratification as a defense against the dread of annihilation resulting from the parallel refusal of all-bad self and object representations that reflect internalized object relations dominated by aggression. It is important to distinguish what takes place during normal symbiosis from the psychotic process. Normally during symbiosis, all-good fused self-object representations result from gratifying relations with the object. Normal introjections build up fused or undifferentiated self-object representations separately under libidinally invested and aggressively invested relations with the object. In contrast, **defensive destruction of or escape from object relations and defensive blurring of the boundary between self and nonself with a consequent loss of reality testing are characteristic of psychosis but not of normal symbiosis.** In normal symbiosis, the infant-caregiver relationship is consolidated, in psychosis, the refused self-object representation has a fantastic quality and implies a withdrawal from object relations in reality. In essence, **psychotic identification is a defense against the dread of annihilation.** In my view, psychotic identifications include two mechanisms: psychotic introjections, characterized by a defensive refusal of all-good self and object representations that threatens the destruction of the self as a consequence of defensive blurring between these self and object representations (Jacobson 1964), and projective identifications, representing efforts to escape from an intolerable world of aggression within which self and object can no longer be differentiated. I have already suggested (chap. 10) that projective identification may constitute the means whereby a distressed infant tries to differentiate itself from the object under conditions of negative peak affects. Normal introjection, in contrast, facilitates the infant's cognitive differentiation of self from object. Extreme pleasure states establish an all-good undifferentiated self-object representation within which self and

- object components will then be gradually differentiated as heightened attention is drawn to these experiences; extreme unpleasure states motivate efforts to escape from and eliminate this unpleasure by placing its source "out there," creating an all-bad fused self-object representation in the process. Here again, self and object are thus gradually differentiated. The effort during normal symbiosis to eliminate an all-bad relationship implies an effort at differentiation but also the creation of a potentially dangerous external reality, which, because it is dangerous, needs to be controlled to avoid "persecution." A potential distortion of external reality occurs here, so that primitive projective mechanisms bear some resemblance to the regressive projective processes in psychosis. In contrast, more adaptive projective mechanisms, encountered in neurotic structures, do not aim at controlling the object of projection. Therefore, as I said in chapter 10, **I designate the earliest or most primitive form of projection projective identification and reserve the term projection for more adaptive, later forms of this defense.** I am using the term projective identification instead of psychotic projection because the former is more current even if the latter is perhaps more accurately descriptive. The normal early projective mechanism and those observed in both psychotic and borderline psychopathology are practically identical, justifying one term—projective identification - for both normal and pathological early projection; and the term projection is most frequently described with characteristics that correspond to later, more adaptive forms of the mechanism observed in neurotic disorders. In contrast, normal introjection and psychotic introjection are clinically different from each other; psychotic introjection is in fact observable only in psychosis. Therefore, I refer to introjection as the normal process and psychotic introjection as its psychotic counterpart. As mentioned in chapter 10, I believe that projective identification is not necessarily a psychotic mechanism, unless the term psychotic is used as a synonym for primitive, an idea I reject. When projective identification occurs in patients presenting a psychotic structure, it represents a last-ditch effort to differentiate self from object, to establish a boundary between the self and the object by means of omnipotent control of the latter. Projective identification is the patient's way of trying to avoid a complete loss of self, which would result in psychosis. Without recourse to projective identification the patient would lapse into a confusional state in which he or she would no longer know whether aggression came from the inside or the outside. In patients with borderline personality organization, whose boundaries between self and object representations and between self and external objects are well differentiated, projective identification serves different functions. Here it is the primitive dissociation or splitting of all-good from all-bad ego states that the patient attempts to maintain. In patients with borderline personality organization, projective identification weakens the ability to differentiate self from external objects by producing an "interchange of character" with the object, so that something internally intolerable now appears to be coming from the outside. That exchange between internal and external experience tends to diminish reality testing in the area of the exchange, but the patient maintains a boundary of sorts between the projected aspects and his or her self-experience. In psychosis, psychotic identifications, including psychotic introjections and projective identification, predominate. These processes lead to delusional distortions or recreation of external objects and pathological efforts to control them within an overall context of loss of reality testing derived from the loss of ego boundaries that results from self-object blurring. Psychotic identifications, as I said earlier, signify regression to an abnormal symbiotic phase. They bring about an obliteration of the self under the influence of psychotic introjection, and destruction of the object world under the influence of projective identification (Jacobson 1964). The ultimate cause of the activation of psychotic identifications is the upsurge of inordinate aggression, which triggers a defensive refusal of all-good self and object representations and activates projective identification to deal with the threatening infiltration of aggression into all internalized object relations." (pg. 193-196)
- "In the course of psychoanalytic treatment, when the analyst communicates to the patient his observations not only about the patient's behavior but also regarding the patient's self-awareness, the boundaries of that self-awareness expand, incorporating the perceptions communicated by the analyst. The patient's self representations also become more sophisticated, absorbing into the self concept the self-reflecting aspects that were the analyst's focus of attention and were incorporated by the patient in identification with him. I suggest that the self always includes two layers, or rather, what might be visualized as a central sphere of self representations and a surrounding sphere of self-reflectiveness derived from identification with the observing and concerned mother in the original dyadic relationship when self and object representations are differentiated from each other. One might also describe this dual nature of the self as a grouping of functions of self representations, one group centering on self differentiation, the other on retaining the observing functions of the parental images internalized into the self." (pg. 206)
  - Chapter 13 - Vicissitudes of and Pleasure in Hatred (pg. 211)
    - "In my experience, primitive hatred may be differentiated from the affect of rage in the transference by its relatively stable, enduring, and characterologically anchored qualities (chap. 2). Regardless of its origin and the concrete unconscious fantasies it encompasses, **the most impressive characteristic of such hatred, as Bion (1970) has pointed out, is the patient's intolerance of reality.** A strange process occurs in the patient dominated by primitive hatred: a common defense against awareness of such hatred is the destruction, by means of acting out, projective identification, and even, at times, a fragmentation of cognitive processes, of the patient's capacity to be aware of it: the patient's mind can no longer "contain" the awareness of a dominant emotion. Thus the defense is at the same time an expression of the impulse against which it is directed. Intolerance of reality becomes hatred of psychic reality directed against the self and against the hated object. Hatred against the self shows directly in self-destructive impulses, such as self-mutilating or suicidal behavior, or in masochistic perversions. Intolerance of psychic reality also brings about a self-directed attack on the patient's cognitive functions, so that the patient is no longer able to use ordinary means of reasoning or to listen to such reasoning from the therapist. Under the sway of intense hatred, the patient may present the combination of focused curiosity, arrogance, and the pseudo-stupidity described by Bion (1957). In essence, the patient attempts to destroy the means of communication between himself and the therapist to erase awareness of his own hatred. In addition, intolerance of the object is reflected in the patient's intense fear and hatred of the analyst, who is perceived as a persecutor. This leads to paranoid developments in the transference, which may go so far as to result in transference psychosis, with what amounts to a desperate display on the part of the patient of projective identification. By means of this defense, the patient attempts to locate his aggression in the therapist by provocative behaviors that reinforce the projection, omnipotent control, and intolerance for any interpretations from the analyst. The intolerance of the therapist as a good object, evidenced in periods when paranoid mechanisms are not in effect and the therapist is perceived as a potentially good object, is reflected in the patient's inordinate greed, the voracity with which he solicits the therapist's attention, time, and interpretive comments, and a concomitant, unconscious destruction of what is received: whatever the therapist contributes the patient experiences as inadequate; the greed continues. A major question is, why is the patient unable to tolerate awareness of the intensity of his rage? Why does he have to deny the pervasive, constant, overwhelming quality of his hatred? **I believe this intolerance is the expression of the deepest fears of losing the love object, originally the good mother threatened by the destructiveness of the patient's hatred. But the patient is immediately, as the result of his intolerance of his hatred, threatened by the fantasy of his own destruction as a consequence of pathological projective mechanisms that transform the frustrating and hated object (the bad mother) into a powerful, dangerous enemy who might well annihilate the patient. The fantasied threat of annihilation, of bodily and mental destruction, is the immediate source of attempts to fight off both the influence of the object and the awareness of the self under the impact of hatred.** The therapist's own hatred in the countertransference, a product of the patient's projective identification and omnipotent control or, more concretely, the natural consequence of the patient's consistently provocative behavior, his active destruction of meaning and of everything he receives in the therapeutic relationship, may generate in the therapist a wish to cut through the madness that invades the sessions, to free himself from endless entanglement in trivial bones of contention that seem to drown all opportunities for the patient's learning in the hours, and to escape from this destructive relationship. To what extent is the patient's intolerance of reality of self and other and the concomitant destruction of the communicative process a defense against, rather than a direct expression of, primitive hatred? I believe that what is typically being defended against under such conditions is the patient's direct experience of hatred as an affect, the derivative affect states of gleeful, sadistic enjoyment of the destruction of the object, and the enjoyment of disgust, contempt, cruelty, and humiliation expressed toward the

object. If and when the patient can tolerate the conscious experience of sadistic pleasure in the transference, a first step in the containment of hatred has been achieved. At this point, the patient is characteristically less afraid of the destructive effects of his aggression; his need to project aggression diminishes, and therefore his perception of the therapist as a bad object diminishes. The patient may now begin to be dimly aware that the object of his love and of his hatred is one. **Hatred exists in a dialectic relation with love. Hatred implies an intense involvement with an object of past or potential love, an object that at some time was deeply needed. Hatred is, first of all, hatred of the frustrating object, but at the same time it is also hatred of the loved and needed object from whom love was expected and from whom frustration is unavoidable. In its origins, hatred is the consequence of the incapacity to eliminate frustration through rage, and it goes beyond rage in a lasting need to eliminate the object. But hatred also has a differentiating aspect; if love is associated with attempts at fusion or merger, hatred attempts to differentiate the self from the object. Insofar as hatred cannot be tolerated and is projected outside the self, it contributes to differentiating self from object and counteracts the urge to merge.** Hatred may thus contribute to differentiation, the experience and testing of personal strength, self-affirmation, and autonomy; hatred may evolve into serving the sublimatory functions of aggression as healthy self-affirmation. It is only at the most primitive level of rage itself—the original source of hatred - that maximum intensity of rage (a peak affect) is experienced as fusion with the object. Primitive hatred at a sustained intense level, however, creates a circular reaction that not only perpetuates but pathologically increases hatred itself. By projective mechanisms, particularly projective identification, rage at the frustrating object brings about distortion of the object, and the frustration is now interpreted as a willful attack. This sense of being attacked by a formerly needed and loved object is the most primitive experience of love betrayed and produces potent resonances throughout the entire sequence of preoedipal and oedipal stages of development. The experience of love betrayed further increases hatred, with even greater amplification of hatred through projective identification; now the object is perceived as cruel and sadistic. The internalization of this distorted object relation perpetuates the experience of an enraged, humiliated, debased self and a cruel, sadistic, contemptuous object; the corresponding derivative ego and superego identifications bring about a general distortion of internalized object relations. The identification with the aggressive, triumphant object in this dyadic relation in turn triggers cruelty and contempt in the expression of hatred toward the object when the intolerable, debased concept of the self can be projected onto it, and, in identifying with the object, aggression toward the self as well. Now the state described a few moments ago has been reached: **hatred is destroying external and internal object relations; the defensive process of destroying the perceiving self to eliminate both pain and dangerous hatred is a major force in the patient's defensive organization.** Projective identification may be replaced by an exacerbation of splitting mechanisms, leading to fragmentation of affective experience and of cognitive processes as well, a development Bion (1959) described. A lesser intensity of splitting may preserve a divided world of idealized and persecutory objects, and of an idealized and a bad self, with alternating behavior patterns clinically reflected in chaotic object relations, in destructive and self-destructive acting out, alternating with defensively idealized relations with objects." (pg. 211-214)

- Chapter 14 - Psychopathic, Paranoid, and Depressive Transferences (pg. 222)
  - See text
- Chapter 15 - The Relation of Borderline Personality Organization to Perversions (pg. 247)
  - "In earlier work (1974a, 1974b, 1980a, 1980b, chap. 14 above) I concluded that **for a man and woman to develop a healthy, stable love relation both partners must, first, have the capacity for broadening and deepening the experience of sexual intercourse and orgasm with sexual eroticism derived from the integration of aggression and bisexuality (sublimatory homosexual identifications). Second, they must have the capacity for an object relation in depth, which includes transforming preoedipal strivings and conflicts in the form of tenderness, concern, and gratitude, and the capacity for genital identification with the partner, coupled with sublimatory identification with (and yet leaving behind) the parental figure of the same sex. Third, they must have the capacity for depersonification, abstraction, and individualization—that is, maturation—in the superego so that infantile morality has been transformed into adult ethical values and a sense of responsibility and moral commitment, which reinforces the couple's emotional commitment to each other.** In exploring jointly the couple's sexual behavior, object relations, and superego functions, I concluded that sexual gratification derives its intensity from a freedom for experimentation that includes the expression of unconscious fantasies reflecting both oedipal and preoedipal object relations. This means bringing sadistic and masochistic, exhibitionistic and voyeuristic elements into the sexual relation and the enactment of complex fantasies. Such developments require time. The enactment of homosexual fantasies as well as of aggressive derivatives of preoedipal relations is included here: in the couple's capacity to transitorily free sexual activity from a rigid relation to a total object relation so that the participants can treat each other as "sexual objects." What is required for this is a capacity for sexual play, contained by an implicit frame of an emotional relation that transcends that play. This conception links intense sexual excitement with the fantasy world of perversion and pornography. Sexual freedom of the couple in love expresses, at one point, polymorphous perverse fantasy that temporarily frees both participants from their specific object relation - although their total sexual involvement is still contained by that object relation. This last characteristic naturally makes sexual play an erotic art in contrast to the restricted, mechanical quality of pornography. I also use the term pornography to focus on one more dimension of sexual freedom— namely, its opposition to socially sanctioned sexual behavior, usually directed against the aggressive and generally pregenital components of sexuality. The aspects of sexuality that are conventionally accepted as part of a couple's love life are typically shorn of the intensity and excitement derived from pregenital features. There is a surprising similarity in the role of aggression in perversion and in normal love relations. The question is, does perversion, with its important function of "metabolizing" aggression, have a role parallel to that of other "metabolizing" mechanisms in normal love relations (such as dissociated regressive interactions or submission to and rebellion against superego functions projected onto the partner? Aggression in a couple's relationship is expressed in the part-object relations activated in sexual play and intercourse, in sadistic and masochistic fantasies and activities, in the use of the partner as an object, and in the excitement of being used in this way. In terms of object relations, aggression is expressed in the normal ambivalence of total object relations and in the specific themes of oedipal competitiveness and rivalry and the activation of "reversed triangularization" - that is, the fantasy and wish for oedipal revenge by introducing a third party into a love relationship and thus threatening one's love object with a rival (Kernberg 1991a). Jealousy is a primary emotion expressing the love and hatred derived from the oedipal situation, perhaps condensed with preoedipal jealousy and envy. In terms of superego functions, aggression is involved in the repression of pregenital components of infantile sexuality and of genital strivings themselves, insofar as these are too directly linked to the oedipal objects. Aggression is also involved in submission to conventional sexuality and to projected superego features directed against sexual wishes. At the same time, the integration of love and aggression in the superego permits firm, stable value systems and internal morality and a sense of concern and responsibility that reflects love as well. This function protects the couple's relationship against the excessive activation of aggression in the normal ambivalence of all intimate object relations, particularly the aggressive components of reversed oedipal triangularization. I am suggesting that polymorphous perverse infantile sexuality serves an important function in the recruitment of aggression in the service of love that characterizes human sexuality. It is as if the transformations of the early experience of pain into sexual excitement, and of the experience of pleasure in aggressive behavior into pleasure in the expression of erotic hostility, provide a quality of elation to sexual arousal linked to the fantasy that sexual wishes as an expression of love and sexual wishes as an expression of aggression are no longer in contradiction (Kernberg 1991b). The resulting condensation provides a sense of power and freedom from conflict and, when contained by the security of a loving object relation, reassurance against the feared consequences of the aggressive side of unavailable ambivalence. Here, I believe, lies an important function of the polymorphous perverse aspects of normal sexuality: they cement the relation of the couple and limit the effects of infantile superego collusions and related social conventionalities. But where are the boundaries between normal polymorphous perverse sexuality and the regressive aspects of aggression in perversion?" (pg. 251-253)
  - **"By perversity I mean the conscious or unconscious transformation of something good into something bad: love into hatred, meaning into**

meaninglessness, cooperation into exploitation, food into feces. Perversity is clearly not the same as perversion, which can be defined as a deviation from a normal sexual function into an idiosyncratic and bizarrely rigidified one. In my experience, only the severest types of perversion, usually in patients with malignant narcissism, present characteristics of perversity in their transference and in other object relations. **Perversity, as I see it, is a quality of object relations that reflects the conscious or unconscious recruitment of love, dependency, and/or sexuality in the ordinary sense in the service of aggression. It reflects the effort to exercise sadistic control and the omnipotence of the pathological grandiose self in malignant narcissism, a "mad" (Rosenfeld 1971, 1975), grandiose self-structure that causes the most severe negative therapeutic reactions. These patients relentlessly extract what is good in the analyst in order to empty him out and destroy him; they do the same in all other close object relations.** In his analysis of transference relationships, Bion (1970) described what he called "parasitic" transference as a relation between two people geared to destroying a third—namely, anything new, what might be called "the analytic baby," that might develop in the course of treatment. In essence, he suggested, in parasitic relations there is a malignant effort to destroy truth and truthfulness, and he pointed to the relationship between the liar and the analyst as the prototype of such a malignant distortion in the transference. There exists a literature on perversity, from the plays of Harold Pinter (1965, 1973, 1978), at one extreme, to the plots of standard thrillers, at the other, built on similar lines: one person, sexually excited and falling in love with a second person, is exploited through this sexual bond by the second person, who, struggling internally with the contradiction between a wish to respond with sexual love and a secret predetermined commitment to betray the first person to a third one, finally yields to betrayal. The drama of this perverse triangle is significantly increased when the first person, knowing that he or she will be betrayed, willingly acquiesces in this destiny, thus internalizing the recruitment of love and sex in the service of aggression. Chasseguet-Smirgel (1978, 1983), stressing the anal quality of the devaluation processes characteristic of narcissistic transferences, pointed to the transformation of all object relations into undifferentiated, devalued "segments" unconsciously representing feces. In her view, the omnipotent denial of the differences between the sexes and between generations and the omnipotent equalization of homosexuality and heterosexuality in multiple polymorphous perverse sexual activities reflect a perverse destruction of object relations by analyzing them. I have observed some patients with malignant narcissism who took direct, conscious pleasure in their destructive engagement with the analyst as they first tried relentlessly to absorb everything from him and then relentlessly dismantled it. Moreover, the patient's wishful fantasy to destroy everything good in the analyst or to transform it into feces even before forcefully extracting it may lead to a frenzied and triumphant orgy of aggression. Typically, when this process cannot be resolved analytically, it culminates in the stage in which the patient feels that he has absorbed everything from the analyst, that what he learned he knew partially all along or discovered by himself, and that it was pretty much worthless anyhow. Interrupting the analysis under such conditions protects him against the fear of aggressive retaliation from the analyst and reinforces, in his fantasy, a sense of omnipotence, defenses against feelings of guilt over his own aggression, and the lack of mourning over object loss. These patients typically induce a sense of chaos and futility in the analyst at such crucial stages of their treatment, reflecting the chaos and futility that characterizes their own object world and even their physical environment. The malignant sense of grandiosity expressed in perversity may find direct expression in actual sadistic perversions, as with the patient who lured women to participate in perverse rituals and then abandoned them. That abandonment had the function of "flushing the toilet," ridding the patient of anally destroyed and potentially poisonous objects. The combination of a fantasied sense of absolute power and control on the part of the pathological grandiose self with which the patient is totally identified under these conditions, of power over the world, with the induction of chaos as part of the anal destruction of the surrounding world leads us directly to the world of the novels of the Marquis de Sade, to the psychology of madness and chaos in the midst of absolute power in Orwell's 1984, and to their counterparts in reality: the cases of sadistic tyrants exerting absolute control and the underlying chaos in the societies thus dominated. The juxtaposition of order and chaos, Saul Friedlander suggests in *Reflections of Nazism: An Essay on Kitsch and Death* (1984), is a frightening yet strangely appealing aspect of certain regressive group processes. The fascination that Nazi Germany is exerting over a new generation of intellectuals trying to understand the appeal of totalitarian ideologies may relate to this fascination with total order and simultaneous destructive chaos. If perversity is based on polymorphous perverse fantasies and activities that disregard the distinctions between the sexes and the generations and unconsciously equate not only all sexual activity but all object relations with fecal matter, and if the mad worlds of de Sade's *120 Days of Sodom* (1785), a fantasy, and of Auschwitz, a reality, represent the rock bottom condensation of aggression and perversion, then "ordinary perversions" that maintain a rigid, obligatory sexual scenario in the context of preserving ordinary genital relations and the capacity for maintaining differentiated object relations represent a truly "innocent" side of perversion." (pg. 255-257)

- **"Projective identification at a most primitive level reflects an attempt to establish distance from intolerable intrapsychic aggression by externalizing it onto an object; the object must then be destroyed because differentiation from it cannot be maintained."** (pg. 261)

- Chapter 16 - A Theoretical Frame for the Study of Sexual Perversions (pg. 263)
  - See text
- Chapter 17 - A Conceptual Model for Male Perversion (pg. 277)
  - See text

c. Further Readings:

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