Aggression and Transference in Severe Personality Disorders

by Otto F. Kernberg, M.D.

Studies of patients with severe personality disorders and of children at high risk for psychopathology have shown growing evidence that early exposure to violence as well as physical, psychological and sexual abuse, particularly incest, are significantly more frequent in their background than in those with milder personality disorders and the population at large (Paris 1993). Yet, evidence is also increasing that abnormality of neurochemical and neurohormonal systems may be related to significant aspects of personality pathology, particularly proneness to aggressive and reckless behavior, pointing to the importance of genetic and constitutional determinants of what is somewhat loosely called "temperament" (Stone 1993). Accepting in theory the possibility that both genetic and constitutional factors and environmental and psychodynamic factors may play roles, the question remains how to conceptualize aggression and understand its involvement in the development of severe psychopathology.

I proposed in earlier work (1992) that affects are instinctive components of human behavior, that is, inborn dispositions that are common to all individuals of the human species. I proposed that they emerge in the earliest stages of development and are gradually organized as part of early object relations into gratifying, rewarding, pleasurable affects or libido as an overarching drive, and into painful, aversive, negative affects which are organized into aggression as an overarching drive. Within this conceptualization, affects are inborn, constitutionally and genetically determined modes of reaction that are triggered first by various physiological and bodily experiences, and then by the development of object relations from the beginning of life on.

Rage, within this conceptualization, represents the basic affect of aggression as a drive, and the vicissitudes of rage explain, in my view, the origins of hatred and envy, as well as of anger and irritability as moods. Similarly, the affect of sexual excitement constitutes the core affect of libido, which slowly and gradually evolves out of the primitive affect of elation. Elation is produced by the infant's early sensual responses to intimate bodily contact with mother.

The proposed theoretical reformulation of the relationship between affects and drives in psychoanalytic theory permits conceptualizing the constitutionally given and genetically determined disposition to intense activation of aggression expressed by means of temperament, that is, the inborn disposition to intensity, rhythm and thresholds of aggressive affect activation. In this connection, cognitive deficits, minimal brain dysfunctions that interfere with the organization of perceptive stimuli and that facilitate the activation of anxiety under conditions of uncertainty, also may contribute to pathological affect activation. A limited capacity for time appraisal and spatial organization, for example, would increase an infant's sensitivity to separation from mother. Most importantly, traumatic experiences, such as intense and chronic pain, physical and sexual abuse, as well as severe pathology in early object relations would operate through the activation of aggressive affects determining the predominance of overall aggression over libidinal striving, resulting in conditions of severe psychopathology. In short, the artificial separation of nature versus nurture can be reconciled by a concept of drives that considers their constituent affect dispositions as their structural underpinnings.

I assume that from the onset of object relations the experience of the self relating to an object during intense affect states generates an intrapsychic world of affectively invested object relations of a gratifying and aversive quality. The basic psychic experiences that will constitute the dynamic unconscious are dyadic relations between self-representation and object representation in the context of extreme elation or rage. Symbolic states of mind—that is, experiences of elation within which an unconscious fantasy of union or fusion between the self and object crystallize—are easily associated with the psychic implications of the baby satisfied at the breast and the baby's elation when in visual contact with mother's smiling face. That states of intense rage also imply an experience of fusion between self and object under the control of such an intense aversive affect is a conclusion derived from the transference analysis of patients suffering from severe psychopathology characterized by intense aggression.
Function of Rage

The earliest function of rage is the effort to eliminate a source of irritation or pain. Rage is thus always secondary to frustration or pain, although the intensity of the rage response may depend upon temperamental features. A second function of rage is to eliminate an obstacle or barrier toward gratification. Here the dynamics are more complex: an obstacle has to be eliminated to reach a fantasied or real source of gratification. This is the prototype for a third, higher developmental level function of rage, namely the elimination of a bad object, that is, a supposedly willful source of frustration standing between the self and the gratification of a need.

At a still more advanced developmental level, the wish is no longer to destroy the bad object, but to make it suffer: here, we are definitely in the complex developmental area in which pleasure and pain combine, sadism expresses a condensation of aggression with pleasure, and the original affect of rage appears transformed into hatred with new, stable, structural characteristics. At a further level of development, the wish to make the bad object suffer shifts into the wish to dominate and control the bad object in order to avoid fears of persecution from it; now obsessive mechanisms of control may psychopathologically regulate the suppression or repression of aggression. Finally, in sublimatory aspects of the aggressive response, the search for autonomy and self-affirmation, for freedom from external control, reflects characteristics of the original, self-affirmative implications of rage.

Hatred, I propose, is a complex, structured derivative of the affect rage that expresses several wishes: to destroy a bad object, to make it suffer and to control it. In contrast to the acute, transitory and disruptive quality of rage, it is a chronic, stable, usually charac-terologically anchored or structured affect. The object relationship framing this affect expresses concretely the desire to destroy or dominate the object. An almost unavoidable consequence of hatred is its justification as revenge against the frustrating object; the wish for revenge is typical of hatred. Paranoic fears of retaliation also are usually unavoidable accompaniments of intense hatred, so that paranoic features, a wish for revenge, and sadism go hand in hand.

One complication of hatred derives from the fact that very early frustration and gratification are experienced as stemming from the same source. Hence, the obstacle to gratification is the origin of that gratification, which brings about the psychopathology of envy. I am referring to Klein's (1957) explanation of envy as a major manifestation of human aggression. Very early frustration—in Klein's terms, the absence of the good breast—is experienced by the baby as if the breast withheld itself, with an underlying projection into the breast of the baby's aggressive reaction to that frustration. The baby's aggression takes the form of greedy wishes to incorporate. The frustrating breast is experienced as greedily withholding itself. Here lies the origin of envy, the need to spoil and destroy the object that is also needed for survival and, in the end, the object of love.

The clinical study of patients with narcissistic personality disorder regularly reveals both unconscious and conscious envy as a major affective expression of aggression. As we move from the better functioning narcissistic pathology to severe narcissistic personality disorders with overt borderline functioning, that is, with generalized lack of impulse control, of anxiety tolerance and of sublimatory channeling, the intensity of aggression mounts, reaching a maximum in the syndrome of malignant narcissism. At times, the intensity of hatred is such that it results in a primitive effort of denial of hatred by means of the destruction of all awareness of the affect, a transformation of aggressive affects into action or acting out; in addition to defending against the subjective awareness of the affect, the action obliterates ordinary cognitive functioning. These developments characterize the syndrome that Bion (1957) described as constituted by arrogance, curiosity and pseudo stupidity: here envy and hatred become almost indistinguishable.

Most patients with severe histrionic, hysteroid or borderline personality disorder, and with severe self-destructive, self-mutilating, suicidal, and/or antisocial trends always also evince strong elements of envy within the context of intense activation of hatred. On the other hand, what might be called the "purest" manifestation of hatred—with relative absence of envy per se—may be seen in patients who were physically traumatized or victims of sexual abuse or incest.

The greater the envy, the more is an actual perception of the envied or hatefully envied person as one who possesses qualities that are highly desirable or "good." In other words, the object of hatred is experienced as an object that in some ways possesses the goodness and values that the patient misses and desires for himself. This development does not take place when pure hatred is directed at an object perceived as a dangerous, sadistic enemy. Hatred aims at the destruction of a source of frustration perceived as sadistically attacking the self; envy is a form of hatred of another perceived as sadistically or teasingly withholding something highly desirable. Typically, although not always, patients with severe narcissistic pathology have a history of a relationship with a parental figure who seemed to be operating as
Storms are expressed in dissociated forms. Transferences prevail: the patient is deceptive, expects the therapist, communication is suppressed, and what I have called psychopathic malignant transformation of the therapist-patient dyad in which all lead to dominant coping of hatred, to block therapist is such that reality itself becomes patient's fear of his or her own hatred and of the hatred attacks, but also with transference regression in borderline Under extreme circumstances, typically seen in schizophrenic panic possesses to fulfill the patient's fearful countertransference that activate whatever role limit the therapist's dangerousness, the induction of the therapist torturer and tortured, transference is the patient's attributing to important clinical manifestation of the hated and hateful, perception it, that is, the hated and hateful, hatred and the related desire to destroy the origin of their Let us now explore some clinical manifestations of patients dominated traumatic conditions, escape a persecutory world syntonic hatred, sadism and borderline personality organization characterized by primitive splitting operations persist. When hatred overwhelmingly dominates an unconscious world of object relations, primitive splitting operations persist. This results in a borderline personality organization characterized by an internal world of idealized and persecutory object relations with a dominance of the latter and their corollary of paranoid tendencies, characterologically structured ego-syntonic hatred, sadism and vengefulness. Dissociated efforts are made to escape a persecutory world by illusory, dissociated idealizations. Under traumatic conditions, then, the basic mechanisms would include the immediate transformation of pain into rage and rage into hatred; hatred consolidates the unconscious identification with victim and victimizer.

Let us now explore some clinical manifestations of patients dominated by hatred and the related desire to destroy the origin of their suffering as they perceive it, that is, the hated and hateful, persecutory object. The most important clinical manifestation of the dominance of hatred in the transference is the patient's attributing to the therapist an intense, relentless degree of hatred. By means of projective identification, the internal world of torturer and tortured, tyrant and slave are enacted in the form of attributing to the therapist the role of sadistic tyrant and, by means of unconscious efforts to provoke the therapist into such a role and to control him or her in order to limit the therapist's dangerousness, the induction of conditions in the countertransference that activate whatever role responsiveness the therapist possesses to fulfill the patient's fearful expectations.

Under extreme circumstances, typically seen in schizophrenic panic and rage attacks, but also with transference regression in borderline patients, the patient's fear of his or her own hatred and of the hatred projected onto the therapist is such that reality itself becomes intolerable. If, under conditions of symbiotic regression in the transference or even intense activation of projective identification in nonsymbiotic conditions, the entire world is a sea of hatred, to block out the awareness of reality is the most primitive and dominant coping mechanism. Efforts to destroy the awareness of reality may lead to psychotic confusional states or, in nonpsychotic patients, to a malignant transformation of the therapist-patient dyad in which all honest communication is suppressed, and what I have called psychopathic transferences prevail: the patient is deceptive, expects the therapist to be deceptive, all communication takes on a pseudo quality, and violent affect storms are expressed in dissociated forms.
Under less extreme conditions, e.g., malignant narcissism, the patient may manifest intense curiosity about the therapist, to the extent of active spying on the therapist's life; the patient shows consistent arrogance and contempt for the therapist, and an incapacity to conduct cognitive communication with the therapist that may amount to a form of pseudo stupidity (Bion 1957). I have described in earlier work (1992) how the gradual working through of such conditions in the transference may eventually give rise to the patient's tolerating his or her hatred rather than having to project it.

Another manifestation of primitive hatred that the patient cannot tolerate in conscious awareness is the transformation of hatred into somatization in the form of primitive self-mutilation: these are patients who chronically mutilate themselves-pick at their skin or mucosas-and present other patterns of primitive sadomasochistic behavior. Character- logically anchored suicidal tendencies in borderline patients are another expression of self-directed hatred.

Recent research (Paris 1994) confirms the importance of the history of sexual abuse as a prevalent aspect of patients with borderline personality disorder as well as their tendency toward dissociative reactions.

What is often striking in such dissociative states is the patient's remarkable indifference to what seems to be a dramatic psychopathological phenomenon: indeed, some patients present an almost defiant affirmation of the "autonomy" of his/her split-off personalities, while refusing to consider any sense of personal responsibility for these phenomena. Often, the mutual dissociation of alternate personality states raises the question of why some apparently not incongruous personality states appear as split from each other.

In my experience, when the clinician asks how the patient's central personality—his or her sense of awareness, concern, responsibility—relates to these split-off personality states, an immediate new development in the transference is triggered. Many patients develop a paranoid reaction to such an inquiry, which evolves into a specific transference disposition in which the therapist appears as a persecutory figure and is contrasted to other persons in the patient's life, including other therapists, who are idealized as helpful, tolerant, nonquestioning, admiring and supportive. And the patient's alternate personality states take on more specific meanings in relation to each split object representations, permitting a clarification of the function of such split states in the transference. In short, approaching the patient from the position of an assumed observing, central, "categorical" self illuminates hidden splits in the transference and permits exploration of the unconscious dynamics involved in the split-personality state that are obscured by the usual, apparently untroubled enactment of these split states.

The patient now may be tempted to angrily accuse the therapist of not believing the existence of his multiple personalities. The therapist's concerned and neutral stand-in being interested in the patient's experience, not questioning its authenticity but at the same time evaluating the implications for the patient's central self-experience—gradually—permits the patient to increase his or her own self-observing function.

In the context of our exploration of the role of aggression and hatred in severe personality disorders, the approach just outlined transforms what appears to be a dreamlike, often affectless dramatization into a concrete object relation in which intense rage and hatred emerge split off from other, idealized, object relations. Once the emergence of mutually split-off peak affect states in the context of split-off primitive object relations becomes evident in the transference, the interpretive integration of these developments may proceed.

This approach is in contrast to a tendency on the part of some therapists to explore the nature of each dissociated personality state while respecting its split-off condition, bypassing the defensive denial of concern over this condition, an approach that may prolong unnecessarily and even may aggravate the dissociative condition itself.

**Further Comments on Treatment**

In the treatment of patients whose transferences are dominated by hatred, it is important, first of all, to establish a rigorous, flexible, yet firm frame for the therapeutic relationship; this step controls life-threatening and treatment-threatening acting out. The therapist has to experience himself or herself as safe, so as to be able to analyze the deep regression in the transference. Setting a contract for patients who are suicidal or who are engaged in dangerous sexual behavior or other types of destructiveness and self-destructiveness encourages the expression of hatred in the transference rather than into the alternative channels of somatization or acting out. As Green (1986) has pointed out, it is extremely important to facilitate the transformation of somatization and acting out into psychic experience in the transference.

When distortion of verbal communication exists, psychopathic transferences should be resolved first. Deceptiveness in the communication is then reduced
sufficiently to enable the underlying paranoid tendencies in the transference to emerge more clearly and be worked through. The therapist should remain alert to the activation of a victim-victimizer paradigm, analyzing in the transference this dyadic relationship as it is repeated, again and again, with role reversals—that is, with the patient's unconscious identification in the transference with both victim and victimizer, as well as projecting, at different moments, these representations onto the therapist. This requires the therapist to be extremely alert to the countertransference: painful experiences of himself or herself as victim and the temptation to act out strong aggressive countertransference reactions as victimizer may alternate.

What must be especially guarded against in the treatment of victims of abuse is the tendency to avoid the analysis of the patient's identification with the aggressor. To treat the patient consistently as victim facilitates the projection of the aggressor role outside the transference, which perpetuates an idealized transference situation dissociated from the basic dyad controlled by hatred; and thus perpetuating the patient's psychopathology. To treat the patient as a responsible adult rather than a perennial victim includes the painful need for the patient to become aware of how, in reaction to the trauma, he or she identified with the persecutor.

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References
Aggressive personalities are fundamentally at war with anything that stands in the way of their unrestrained pursuit of their desires. Yet, the official diagnostic manual of mental disorders recognizes only one small subtype of these personalities as disordered. The manual confers the “disorder” status basically to career criminals and even fails to distinguish or recognize the most severely disturbed character — the psychopath (alt: sociopath) as a distinct personality type. In the next several posts, I’ll be exploring the defining characteristics of a group of personality types that I call the aggressive personalities. Not all of the aggressive personalities engage in criminal behavior, but all pose problems for relationship Transference-focused psychotherapy (TFP) will include more family contact than would be expected in a traditional psychoanalytic treatment. The TFP assessment process will include family involvement if the patient is dependent on family support in any significant way. The TFP therapist’s meeting with the patient and family will include psychoeducation about personality disorders and an explanation about the central tenets of TFP. Many families will benefit from a clear discussion of the uses and limitations of pharmacotherapy for personality disorder symptoms. Family involvement is a helpful r Otto Friedmann Kernberg. In this book, Otto F. Kernberg explores the role of aggression in severe personality disorders and in normal and perverse sexuality, integrating new developments in psychoanalytic theory with findings from clinical work with severely regressed patients. The book also integrates Dr Kernberg’s studies of the descriptive, structural, and psychodynamic features of problems stemming from pathological aggression with the vicissitudes of their psychoanalytic treatment. Finally, Dr Kernberg demonstrates the importance of differential diagnosis for effective psychoanalytic
Otto Friedmann Kernberg. In this book, Otto F. Kernberg explores the role of aggression in severe personality disorders and in normal and perverse sexuality, integrating new developments in psychoanalytic theory with findings from clinical work with severely regressed patients. The book also integrates Dr Kernberg's studies of the descriptive, structural, and psychodynamic features of problems stemming from pathological aggression with the vicissitudes of their psychoanalytic treatment. Finally, Dr Kernberg demonstrates the importance of differential diagnosis for effective psychoanalytic Borderline personality disorder (BPD) is a severe disorder of personality, described as a psychiatric diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV 4th Ed.; From: Vitamins & Hormones, 2015. Related terms Two distinct personality traits, impulsive aggression and affective instability, which appear to have strong biological correlates, co-occur in patients with BPD. Each of these traits has been shown to run separately in families of patients with BPD, and when they coincide in a relative, that individual is likely to meet criteria for a diagnosis of BPD. D. Personality Disorder Not Otherwise Specified. 10. Phenomenologically Corresponding Axis I & Axis II Disorders, Potential Biological Indexes, and Characteristic Traits (Core Vulnerabilities), Defenses and Coping Strategies of Dimensions of Personality Disorders. Dimension. Axis I Disorder. Axis II Disorder. Biological Indexes. Characteristic Traits. Defenses and Coping Strategies.