MONICA CARSKY, PH.D.
STEVEN ELLMAN, PH.D.

OTTO KERNBERG

Psychoanalysis and Object Relations Theory; the Beginnings of an Integrative Approach

BEYOND FREUD

OTTO KERNBERG: PSYCHOANALYSIS AND OBJECT RELATIONS THEORY; THE BEGINNINGS OF AN INTEGRATIVE APPROACH

MONICA CARSKY, PH.D.
STEVEN ELLMAN, PH.D.

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OTTO KERNBERG: PSYCHOANALYSIS AND OBJECT RELATIONS THEORY; THE BEGINNINGS OF AN INTEGRATIVE APPROACH

MONICA CARSKY, PH.D.
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It is a difficult task to attempt to summarize and critique Otto Kernberg's psychoanalytic contributions, for he has presented the most systematic and wide-sweeping clinical and theoretical statements of the last decade, perhaps even since Freud. His work touches on many if not most of the topics that have been of interest to contemporary analysts. In addition, he has been instrumental in introducing many topics to the American psychoanalytic community. Even reviewers who have been sharply critical of Kernberg, such as Calef and Weinshel (1979), have stated that "no other single colleague has been so instrumental in confronting American psychoanalysts with Kleinian concepts and theories" (pp. 470-471). Clearly, this is damning Kernberg with faint praise, since much of the American psychoanalytic community is in opposition to many aspects of Melanie Klein's theoretical contributions. Although there is no question that Kernberg has been strongly influenced by Kleinian concepts, however, there is also no question that he is attempting to integrate many different parts of what is called the British object relations school, as well as aspects of Freudian thought, ego psychology, and different strands of research in neurophysiology and physiological

psychology. This list is by no means complete. Kernberg is strongly interested in research in affect, for example, whether from psychoanalysis, physiology, or academic psychology.

Given that we are dealing with a theoretical integration of such large proportions, one that blends the familiar and unfamiliar, it is not surprising that a number of critics have pointed out various difficulties in Kernberg's theoretical attempts. Before we try to evaluate Kernberg's writings, it is important to put our critical stance into an appropriate historical perspective. In our opinion, there is no psychoanalytic theorist whose theory would stand up to some of the criticism that has been directed at Kernberg. Psychoanalysis has yet to produce a full theory as defined by philosophers of science such as Nagel (1961) or Popper (1962). Leaving aside philosophical conceptions of theory, it is clear to most students of Freud's or Hartmann's writings that many concepts remain without clear definition and are not well integrated into a theoretical structure. If we are to evaluate Kernberg reasonably, it must be within contemporary psychoanalytic standards. In addition, much of contemporary criticism in psychoanalysis is not based on either logical or empirical grounds but rather is often simply or mostly a reflection of the critics' values. We will attempt to evaluate Kernberg's contributions in terms of both his stated aims and our view of the state of contemporary psychoanalytic theory.

Some of our views of contemporary theory have been stated elsewhere

(Ellman & Moskowitz, 1980; Moskowitz & Ellman, unpublished manuscript), but for this introduction we will briefly restate them. We believe that in many of the social sciences it is difficult to state clearly how the different aspects of a theory are organized. Thus, at times, it may not be clear what are the central assumptions of a given theory, as opposed to assumptions or statements that are more peripheral. Frequently, the coordinating logic (see Nagel, 1961) of a theory is also unclear, so that it is hard to know what assumptions should be combined to predict or to explain a given event. Most often, however, the phenomena to be explained are relatively clear and are at least somewhat separated from the theory itself. Psychoanalytic theory shares some of these difficulties, and it is not clear at times what phenomena some psychoanalytic theories are addressing.

Fortunately, Kernberg usually indicates clearly what phenomena he is trying to explain. In our discussion, we will initially introduce the clinical phenomena that have been the main impetus for Kernberg's theorizing, and from that point on will go back and forth between Kernberg's theorizing and the clinical phenomena or observations he wishes to explain. It will be clear as we proceed that the observations and the theory become more and more intertwined. Nevertheless, we think that Kernberg is attempting to explain important clinical phenomena. In fact, this is a major reason for his present importance in psychoanalysis. We do not believe that Kernberg's clinical observations are simply or mainly an artifact of his theorizing.

It may be hard to see in the present context why it would be necessary to mention any of Freud's writings. From our point of view, however, there is a somewhat neglected aspect of Freud's work that is particularly germane to most object relations theorists. (We are obviously including Kernberg as an object relations theorist.) This is most clearly seen in Freud's metapsychological papers, where he frequently presents his views on early development. Certainly Freud's (1915) view of the developmental phase that he termed the purified pleasure ego has been included in one form or another in the work of a number of contemporary authors (Kohut, 1966, 1971; Mahler, 1968; Mahler, Pine, & Bergman, 1975). In these writings, Freud deals with what he termed the origins of the three polarities of the mind and sets the stage for the differentiation of types of identification processes. That is, Freud (1914, 1917) began to conceptualize the process of introjection or early identifications with more specific and developmentally later types of identifications. Melanie Klein, in many ways, expanded on this phase of Freud's work, as well as Freud's theory of instinct[1] as stated in *Beyond the Pleasure Principle* (1920). To greatly oversimplify Klein's work, one may say that she was the first psychoanalytic theorist to attempt to integrate object relations and instinctual points of view. Kernberg has clearly stated that he is also attempting to unite drive and object relations points of view. In addition, he is attempting to stay within a general ego psychological framework, so that the psychoanalytic conception of drive that Kernberg is utilizing arises from Hartmann's emendations and clarifications of Freudian theory. Thus, in a

later era, Kernberg is attempting to integrate important aspects of the British object relations and ego psychological points of view. Given this broad statement, we should point out that many different and at times divergent points of view are encompassed both between and within these two so-called points of view. Kernberg is both eclectic and selective, but he is trying to utilize the concepts that he regards as essential to each position.

Kernberg has attempted to combine at least four elements from either an ego psychological or object relations perspective. These are the following:

1. *Structure*. Although Kernberg has moved the concepts such as self-representation, self-image, and so forth into a more central focus, he has retained Freud's tripartite structure of ego, id, and superego. As we will see, with most of these concepts Kernberg utilizes object relations theorizing to a greater extent when dealing with questions of structuralization early in childhood development and utilizes the tripartite model in later childhood development, particularly in the oedipal period.

2. *Defense*. Although defense is certainly a part of structure, the concept of defense is important enough in Kernberg's writings to warrant special notice. By and large, what Kernberg calls low-level defenses are those that have been discussed by object relation theorists (such as splitting and projective identification), whereas most of Kernberg's high-level defenses (such as

repression and isolation) stem from Freudian and ego psychological theorists. In Kernberg’s conceptualizations, the main defenses utilized are thus an important indication of the general state of an individual’s psychological structure.

3. *Development*. Kernberg has attempted to integrate the concept of object relations phases (schizoid, depressive phase) with the concept of psychosexual development and Mahler’s (1968; Mahler, Pine, & Bergman, 1975) developmental findings. Here again, one may see the viewpoint of Mahler and object relations being used more extensively in considering preoedipal development, while Kernberg utilizes ego psychological concepts in considering oedipal development.

4. *Instinct or drive*. This is a concept that Kernberg has consistently maintained in his theorizing. Since some object relations theorists, such as Fairbairn or Guntrip, have explicitly rejected Freud’s, Hartmann’s, or Klein’s concept of drive, Kernberg is not combining two points of view but rather including this aspect of Freudian ego psychological theorizing in his theoretical framework. In fact, with respect to the concept of drive, Kernberg attempts to integrate segments of modem neurophysiology and neuropsychology with a psychoanalytic concept of drive. It should be pointed out that Kernberg’s conceptualization of emotion and affect are particularly important in his theorizing, and for Kernberg (1976, 1980c, 1982h) these concepts to some extent replace drive as a motivational concept.

The main focus of Kernberg's theorizing is the type of patients that the British school (Balint, 1968; Fairbairn, 1952; Guntrip, 1968, 1971; Winnicott, 1965,1975; and others) has been describing for the last 30 to 40 years. Kernberg has grouped these patients and maintains that many of these other theorists wrote about people who manifest borderline pathology.

In describing Kernberg's work, we will first note the clinical observations which Kernberg's theory seeks to explain. Then we will present summaries of his contributions in five areas: (1) development; (2) psychoanalytic classification of character pathology, including the borderline diagnosis; (3) treatment implications, derived from the developmental theory and diagnostic system, including the rationale for various treatment recommendations as well as Kernberg's view of countertransference and the therapeutic stance; (4) groups and institutions, including issues in hospital treatment; and (5) a theory of drives and affects. Finally, we will comment on Kernberg's critics and will ourselves critically review what we consider to be major elements in Kernberg's contributions to psychoanalytic theory.

SUMMARY OF KERNBERG'S WORK

THE CLINICAL OBSERVATIONS

Kernberg's clinical observation of "borderline adults" has been one of the

factors that has led him to expand “traditional” psychoanalytic theory. He observes that this type of person can often maintain rapidly fluctuating, contradictory ego states. These ego states can be manifested as rapidly changing, intense transference reactions (from idealization and love to intense hatred and rage) and can also be seen in initial clinical contacts. Kernberg (1967, 1975a, 1980c) has inferred that these contradictory ego states are actively separated or split and that a person who shows splitting cannot reconcile these contradictory states. In fact, if someone else points out the person’s contradictory attitudes, states, or actions, the person would always manifest anxiety. A person’s reaction to such an intervention is an important diagnostic indicator to Kernberg (1976, 1981f).

Kernberg feels that when analysts and therapists do not recognize that splitting is taking place they may fail to understand what is happening in a therapeutic situation. He notes a tendency for alternating transference states to remain static when therapy is viewed over a long period of time. The analyst sometimes takes one of the positive states to be the manifestation of a good working alliance or, alternately, might feel that a patient’s rageful attacks may represent an important breakthrough, in which the patient may become aware of and begin to understand these “primitive impulses.” Kernberg believes that often no intrapsychic change is taking place. Instead, the patient simply alternates presentation of these states. Often, the patient uses the tolerant atmosphere of therapy to derive greater gratification of (in particular) his or her aggressive

impulses than would be allowed elsewhere. Or, as in the Menninger study of the effects of supportive psychotherapy (where there was little transference interpretation, and signs of latent negative transference, especially, were unacknowledged), the patient-therapist relationship is shallow or mechanical (Kernberg et al, 1972).

Kernberg points out that according to traditional observations of this patient population (Federn, 1947; Frosch, 1960; Knight, 1954; Schmideberg, 1947; Zetzel, 1971) they tend to lose the ability to test reality adequately in the context of the psychotherapy (transference psychoses), to act out severely, and to consciously experience primary process material while apparently lacking a capacity for introspection and insight.

The primitive, early reactions of borderline patients to their therapists seem to be not only preoedipal in content, but also less organized than neurotic transference. Kernberg (1976) concludes that the work of various object relations theorists (Klein, Fairbairn, Guntrip, etc.) described these reactions most accurately as recreations of early actual or fantasied object relationships—as “the pathologically fixed remnants of the normal processes of early introjection” (p. 25).

These observations and conclusions led Kernberg to propose both a developmental model to account for borderline pathology and technical

innovations for the psychotherapy of borderline conditions.

THE DEVELOPMENTAL MODEL

Kernberg's (1966, 1975a, 1976) developmental model is organized around the internalization of object relationships, a process he takes to be crucial in the formation of psychic structures. He posits three types of internalization or, in his terms, three different identification systems. Each process results in a psychic structure, which is named accordingly (introjects, identifications, and ego identity). Thus, the process of introjection results in an introject, and so forth. As Kernberg (1976) described it: "All processes of internalization consist of three basic components: (a) object-images or object-representations; (b) self-images or self-representations; and (c) drive derivatives or dispositions to specific affective states" (p. 26). Psychic organization takes place at two levels. In the earlier and more basic organization, splitting is the main defense mechanism; during these periods, self-object-affect (S-O-A) units with opposite affective tones are unintegrated, either as a passive consequence of lack of maturity or as active process (splitting). In the more advanced level of organization, repression is the main defense utilized. Ego and superego development and integration can be assessed by the degree to which repression and its associated higher-level defenses have succeeded the more primitive condition (Kernberg, 1976).

Kernberg follows Melanie Klein (1946) in taking introjection to play an

important role in the early development of the ego. However, he suggests that it is a mechanism based on primary autonomous functions of perception and memory, rejecting Klein's views of the importance of very early oral incorporative *fantasies*. We will, at a later point, describe Kernberg's more detailed account of the relationship between his model and findings in cognition, perception, and neurophysiological processes.

Kernberg (1976) defines introjection as "the reproduction and fixation of an interaction with the environment by means of an organized cluster of memory traces" (p. 29) with the S-O-A components. For him those components are "(i) the image of an object, (ii) the image of the self in interaction with the object, and (iii) the affective coloring of both the object-image and the self-image under the influence of the drive representative present at the time of the interaction" (p. 29). Introjection goes beyond the primary apparatuses because it entails complex organization of the results of perception and of memory traces, in which perception of the external world is linked to perception of subjective experience. Although the earliest introjections do not clearly differentiate self and object images, a dyadic element is present.

The affective tone of the introjection is important because the various S-O-A introjections are gradually sorted and organized by affective valence. Kernberg (1976) writes "Introjections taking place under the *positive valence* of libidinal instinctual gratification, as in loving mother-child contact, tend to fuse and

become organized in what has been frequently called “the good internal object.’ Introjections taking place under the negative valence of aggressive drive derivatives tend to fuse with similar negative valence introjections and become organized in ‘the bad internal objects” (p. 30).

Kernberg sees affect in the first months of life as particularly important. Its “irradiating” effect on introjects (which may include perceived self and object representations) is such that the resulting perceptual constellations differ most according to their associated affective states. Affect states, then, are the manner in which introjects of opposite valence are kept apart, since the immature psyche is unable to integrate different temporal experiences and opposite affective experiences.

Although Kernberg stresses the importance of affect in building up separated S-O-A units, his account of developmental stages parallels that of Mahler (1968; Mahler, Pine, & Bergman, 1975). His stages may be summarized as follows:

Stage 1. This is the stage of normal autism, or primary undifferentiation in the first month of life, before the “good,” combined selfobject constellation develops through positive experiences. Pathology at this stage would mean that this undifferentiated image would not develop, and a normal symbiotic relationship with the mother would not take place, being replaced by autistic

psychosis.

Stage 2. This stage, normal “symbiosis,” from the third or fourth to the sixth or ninth month, consists of the consolidation of an undifferentiated, “good” self-object representation, and corresponds to the periods of Mahler’s symbiotic phase and differentiation subphase. Even when self- and object images begin to be separated-still within the umbrella of libidinally organized S-O-A units-they are weakly delineated, and, Kernberg (1976) says, there is a “persisting tendency for defensive regressive refusion of ‘good’ self and object images when severe trauma or frustration determine pathological development of this stage” (p. 60). Fixation at, or regression to, this self-object dedifferentiation and loss of ego boundaries is typical of childhood symbiotic psychosis (Mahler, 1968), most types of adult schizophrenia (Jacobson, 1954), and depressive psychoses (Jacobson, 1966).

Stage 3. In this stage, self- and object representations are clearly differentiated, within both the core “good” self-object and core “bad” self-object. Self-images from one positively experienced S-O-A unit are linked with those from other positively valenced S-O-A units, with parallel joining of object representations. With the increasing complexity of the resulting representations, this process “contributes to the differentiation of self and other and to definition of ego boundaries” (Kernberg, 1976, p. 30). This stage corresponds to Mahler’s separation-individuation phase (excluding the differentiation subphase), and lasts from 6 to 9 months of age through 18 to 36 months. Object constancy (Hartmann,

1964) and stable ego boundaries should be achieved, but relationships are still with part objects. Integration of self- and object representations occurs only at the close of this stage. Kernberg follows Mahler in suggesting that borderline pathology follows from fixation and/or regression to this phase of internalized object relationships.

This is the stage in which active separation (the defense of splitting) between good self-images and bad self-images and between good object and bad object images occurs. In patients with borderline pathology, the combined S-O-A units of opposing valence persist in an unintegrated fashion, and are not replaced or accompanied by higher-level developments. Kernberg (1976) maintains that when opposing S-O-A units are initially introjected, they are kept apart to avoid the anxiety associated with the negative valences "from being generalized throughout the ego," and to "protect the integration of positive introjections into a positive ego core" (p. 36). However, defensive splitting represents a later development, in which the opposing S-O-A units are actively separated.

Kernberg suggests that the ego comes into being at the point when introjections are used defensively. This is a state in which the "good internal objects" (mostly undifferentiated self- and object representations with a positive valence) along with the "good external objects" (positively experienced aspects of reality), form the purified pleasure ego, while the negative S-O-A units are viewed as outside. "Good" self-images and "good" object images begin to be separated.

Slightly later, all these "units" become more elaborate, and the differentiation between "good internal objects" and "good external objects" occurs. Now the defense of projection can be utilized across a relatively clear boundary, so that the array of "bad external objects" includes some that are "bad" via projection of introjections that had a negative valence. This clear utilization of projection is an important development of Stage 3. Correspondingly, the defensive use of active splitting decreases over time, and the individual successfully traverses to Stage 4.

Although we have been focusing on the building up of S-O-A units and the unfolding of defensive processes, the second internalization process, identification, also begins to be used in Stage 3. This is a higher-level form of introjection, which includes the role aspects of the interpersonal interactions and hence requires some development of perceptual and cognitive abilities so that socially recognized functions can be conceptualized by the child (Kernberg, 1976, p. 31). The affective components of such internalizations are also more advanced and differentiated than those associated with introjections. The view of the self is likewise more differentiated, so that it is possible to view the object taking a role with respect to the self. Identifications, like introjection, contribute to the formation of psychic structure and yet may also be used for defensive purposes. Identification continues as a process throughout life at different levels of ego integration, and its results are more subtle and better integrated when the ego is more integrated and splitting mechanisms are not used (Kernberg, 1976, p. 77). In psychotic identifications, where self- and object images are pathologically

refused,[2] identifications are distorted by the projection of primitive superego forerunners or repressed drive derivatives onto the object, so that the internalized object relation is altered in the direction of “all good” or “all bad” introjections. When pathological identifications occur at a more integrated level, they result in pathological character traits.

Stage 4. In Stage 4, contradictory self- and other representations are integrated into percepts of the self and others that more accurately reflect complex experiences of the self and other persons. Failure to achieve this integration results in “identity diffusion.” In this stage, repression appears as a defense, and ego, superego, and id are also differentiated. This period begins toward the end of the third year of life and continues through the oedipal period. Pathology from this stage is that of patients with neuroses or “higher-level” character pathology (hysterical, obsessive-compulsive, and depressive-masochistic characters).

Narcissistic personality disorders may also result from abnormal development during this stage, when instead of integration of self and object, there is, in Kernberg’s (1976) words, “(1) a pathological condensation of real self, ideal self, and ideal object structures; (2) repression and/or dissociation of ‘bad’ self-representations; (3) generalized devaluation of object representations; and (4) blurring of normal ego-superego boundaries” (p. 68; see also Kernberg, 1982f). This results in a grandiose self, which is separated from negatively

valenced S-O-A experiences in a splitting process more typical of Stage 3.

Kernberg interprets Stage 4 as representing the achievement of what Klein (1948a,b) termed the "depressive position," in which, because of the new, more complex view of others as the objects of both hatred and love, both guilt and concern begin to appear. Representations of an ideal self and ideal object develop as wishes to counteract the increasingly accurate awareness of reality. Repression, which prevents the irruption into consciousness of various drive derivatives, separates id from ego during this stage, and the id becomes more organized. Hence, in neurotic or other higher-level psychopathology, one does not readily see primary process or direct expression of drives.

Integration of the superego as an independent intrapsychic structure takes place in Stage 4. This has two aspects: the condensation of ideal self- and object images into the basis of the ego ideal, and the integration of this with the sadistically determined superego forerunners. These superego forerunners are what Kernberg (1976) terms the "fantastically hostile, highly unrealistic object images reflecting 'expelled,' projected and reintrojected 'bad' self-object representations…and reflecting primitive efforts of the infant to protect the good relationship with the idealized mother by turning the aggressively invested images of her (fused with the respective self-images) against himself" (p. 71). With integration come decreases in projection and in the fantastically hostile and unreal nature of the superego elements.

Ego identity, the third process in the internalization of object relations, begins to occur in Stage 4. Ego identity is “the overall organization of identifications and introjections under the guiding principle of the synthetic function of the ego” (Kernberg, 1976, p. 72). This refers to the organization of a self-concept and of deeper, more realistic concepts of others.

Stage 5. Consolidation of superego and ego integration takes place in Stage 5, and ego identity continues to evolve. The individual is able to learn from experience, and “an integrated self, a stable world of integrated, internalized object representations, and a realistic self-knowledge reinforce one another^ (Kernberg, 1976, p. 73). Representations of a social and cultural world are included. The internal world gives increasing meaning to present interactions and provides support for the individual in times of crisis. The individual has the capacity to discriminate subtle aspects of him-or herself and of others and develops “depersonified” attitudes and values with increasing capacity to communicate views and experiences in a way that others can understand. These capacities are absent in pathological conditions organized at earlier stages; the most striking example is the narcissistic personality, who cannot convey more than a shallow sense of who he or she is or who the other is in an interaction (Kernberg, 1976, p. 73). Although intimate connections among drives, affects, object relations, and cognitive and other ego functions are implied throughout Kernberg’s model, these form a particularly complex and dense matrix in the successful outcome of Stage 5—the healthy personality.

THE PSYCHOANALYTIC CLASSIFICATION OF CHARACTER PATHOLOGY

Kernberg's (1980a) model of psychopathology is primarily a conflict model; constitutional deficits may contribute to the intensity of certain conflicts and hence render the development of pathological ego structures or character traits more likely. For example, an infant constitutionally endowed with an intense aggressive drive may project more aggressively tinged S-O-A units onto external figures and may develop pathologically intense fears of castration directed at abnormal images of dangerous parents (Kernberg, 1975a). Or, children with organically based perceptual or other learning problems may have introjections and identifications distorted by their faulty apparatuses of primary autonomy. However, when considering adolescent and adult patients, Kernberg's position is that character pathology is best understood and interpreted as the result of dynamic conflicts. Even if a learning disability is present in a borderline patient, only after considerable treatment can its effect be differentiated from the results of pathological splitting and associated primitive defenses (Kernberg, personal communication).

LEVELS OF CHARACTER PATHOLOGY

The developmental model previously outlined is the basis for a highly specific classification of higher-level, intermediate, and lower-level (borderline) character pathology. This classification is based on determining the level of instinctual development, superego development, defensive operations, and

internalized object relations (Kernberg, 1976). Kernberg (1980,1981c) has been a vocal critic of the DSM-III (American Psychiatric Association, 1980) categorization of personality disorders, because it fails to consider these psychoanalytic perspectives and thereby omits certain important diagnostic entities. In Kernberg's system, higher-level character pathology is marked by the achievement of genital primacy in the instinctual sphere; a well-integrated but excessively severe superego; defense mechanisms organized around repression (including intellectualization, rationalization, undoing, and higher forms of projection); and a stable, well-integrated concept of self and others. Most hysterical, obsessive-compulsive, and depressive-masochistic personalities are in this group—the classical neurotic patients.

At the intermediate level, pregenital fixation points are present, the superego is less well integrated than in higher-level pathology, and sadistic superego precursors play an important role. Defenses are organized around repression, but some more primitive defenses are present, with more infiltration of instinctual impulses than is present in the more sublimatory or reactive traits characteristic of higher-level pathology. Ego identity is established, and there is a stable concept of self and others, but object relations are quite conflicted. Many oral, passive-aggressive, sadomasochistic, and better-functioning infantile personalities and some narcissistic personalities are at this level.

Lower-level character pathology is characterized by borderline personality

organization with, in the instinctual realm, “pathological condensation of genital and pregenital instinctual strivings…with a predominance of pregenital aggression” (Kernberg, 1976, p. 141). Lack of superego integration and the continuing influence of sadistic superego forerunners are more marked than in the intermediate group. Defenses are organized around splitting, with primitive forms of projection, denial, and other mechanisms, which allow partial expression of the rejected impulse to a greater degree than in the other levels of pathology. Object constancy is not firmly established, identity diffusion is present, and object relationships are conceptualized in terms of part objects.

THE BORDERLINE CONCEPT

Kernberg is one of a very small number of investigators who have actually given a detailed definition of the term “borderline personality.” He provides a description of the intrapsychic structures and other concepts he considers relevant to this diagnosis along with a sophisticated phenomenological description of the patients. Kernberg prefers the term “borderline personality organization” to “borderline state” or “borderline personality disorder,” underlining his belief that such patients have a specific and stable personality organization characterized by ego pathology, which differs from neuroses and less severe character disorders on the one hand, and the psychoses on the other. These patients suffer from a particular type of psychic organization, which has a certain type of history and resistance to rapid change. They are not in a transitory “state,”

fluctuating between neurosis and psychosis, nor are they defined solely by their obvious symptoms, as in psychiatric use of the term “disorder.” Kernberg (1967, 1975a) stresses that similar symptomatology may occur as a result of different intrapsychic configurations and conflicts, so that very detailed diagnostic study is necessary.

Kernberg’s delineations of borderline and narcissistic patient groups rely on description of symptoms and complaints presented by these patients, but also, just as important, on inferences about types of psychic structure, defenses, and predominant conflicts. In his concern with “internalized object relations,” he has devoted considerable work to explicating the method by which one makes inferences about this and other hypothetical constructs, such as defenses or structures, on the basis of a patient’s interview behavior, for example.

On a descriptive level, patients suffering from borderline personality organization present symptoms that, if occurring in combination, suggest pathological ego structure: chronic, diffuse anxiety; poly-symptomatic neuroses (severe phobias, rationalized obsessive-compulsive symptoms, multiple, elaborate, or bizarre conversion symptoms, dissociative reactions, hypochondriasis with chronic rituals and withdrawal, and paranoid trends with other symptoms); polymorphous perverse sexual trends; impulse neurosis; and addictions (Kernberg, 1975a). Certain lower-level character disorders (infantile, narcissistic, antisocial, and “as-if” personalities) and paranoid, schizoid,

hypomanic, or cyclothymic personalities also usually have borderline structure.

Inferences about the patient's psychological organization are based on other observations. "Nonspecific manifestations of ego weakness" are noted by assessing lack of anxiety tolerance, as when additional anxiety results in further symptom formation or regressive behavior; lack of impulse control, where any increase in anxiety or drive pressure results in unpredictable impulsivity; the lack of developed sublimatory channels (here the patient's talents and opportunities must be considered). A second sign is the appearance of primary process thinking, particularly in unstructured situations such as projective psychological testing (Carr, Goldstein, Hunt, & Kernberg, 1979; Kernberg, 1975a). The presence of the primitive defensive operations of splitting, projective identification, denial, primitive idealization, and devaluation are important signs of borderline pathology. These may require subtle inferences from interview behavior or interactions with the interviewer over a period of time to establish their presence.

THE STRUCTURAL INTERVIEW

Aside from the presumptive diagnostic elements that may be indicated by a patient's history or presenting complaints, evidence for structural organization is found in the patient's reactions to being interviewed in a way that focuses on the ego functions and features characterizing neurotic, borderline, and psychotic

structures (Kernberg, 1981f).

In particular, the interviewer wishes to understand (1) the degree of identity integration, (2) types of defenses, and (3) the capacity to test reality, including the subtle ability to "evaluate the self and others realistically and in depth" (Kernberg, 1981f, p. 171). Borderline disorders may be differentiated from psychoses by the borderline patient's ability to test reality in the sense that distinctions between internal and external and self and object representations remain. In contrast to neurotic patients, however, persons with borderline structure will show identity diffusion, lower-level defenses similar to those used by psychotic patients, and subtle alterations in the relationship to reality and feelings of reality. Because their capacity to appreciate ordinary social reality is intact, however, and because their defenses protect against the anxiety of intrapsychic conflict (rather than the anxiety of dedifferentiation, as in the psychoses), they respond to interpretations in the interview with better functioning or, at least, without regression.

Thus, the interviewer seeks to assess the patient's view of his or her problems, understanding of self and others, and ability to make use of the interviewer's questions and tentative interpretations. The interviewer focuses on areas that seem odd, contradictory, or unclear to see if the patient can also observe such contradictions and appreciate the possible explanations for these offered by the interviewer.

The “pathology of internalized object relationships,” which contributes to the borderline diagnosis, also relies on complex inferences from character traits and the patient’s behavior with the interviewer. Kernberg (1976) states: “These patients have little capacity for a realistic evaluation of others and for realistic empathy with others; they experience other people as distant objects, to whom they adapt ‘realistically’ only as long as there is no emotional involvement with them” (pp. 36-37). They do not empathize well with others, and are “ignorant of the higher, more mature and differentiated aspects of other people’s personalities” (p. 37). Hence their relationships are shallow, they are unable to experience guilt and concern, and they give evidence of exploitiveness and unreasonable demands without signs of tact or consideration. In trying to control his or her environment, the patient manipulates others. When they begin psychotherapy, these patients immediately present chaotic and primitive object relations in the transference, as opposed to the gradual unfolding of more mature and then less mature transferences found in neurotic patients (Kernberg, 1976).

SPECIAL DIAGNOSTIC ISSUES

Several examples exemplify Kernberg’s contention that similar symptomatology may stem from different types of underlying pathology and structure.

Hysterical versus Infantile Personality. Hysterical patients, while showing

superficial similarities to infantile patients, have some conflict-free areas where their functioning is stable and appropriate. They are impulsive or clinging only in certain relationships or areas of conflict. Their need to be loved and admired, although it has oral, dependent components, is closer to an expression of genital needs. Oedipal dynamics contribute to differential relationships with men and women, and the provocativeness of these patients is usually not accompanied by promiscuity. Stable, if neurotic, heterosexual relationships are present.

In contrast, infantile patients are more socially inappropriate and impulsive across all areas of life. Oral, demanding elements are more prominent, so that the need to be loved is “more helpless” in quality, and exhibitionistic trends have a primitive, narcissistic, exploitive quality. Promiscuity may be present in conjunction with unstable, changing relationships (Kernberg, 1975a). Such patients frequently are organized at a borderline level (Kernberg, 1981c).

Depression. Kernberg stresses the importance of differentiating depression as a symptom from depressive-masochistic character traits. The higher-level depressive personality, for example, may experience depression in connection with guilt over oedipal strivings or with true concern for the self and others, because of the presence of superego integration. Depression that represents helpless rage or disappointment in an ideal suggests less superego integration. Severe depression that causes breakdown in ego functioning also suggests the presence of a sadistic superego, probably associated with borderline organization.

However, both the quantity and quality of depression must be considered when making a structural diagnosis, as the absence of any depressive concern or guilt for others may also be a sign of borderline organization in narcissistic and antisocial personalities (Kernberg, 1975a, 1977a).

Adolescence. The stresses of identity consolidation in adolescence may, in conjunction with environmental pressures (such as gang membership or cultural norms), suggest the presence of severe personality disturbance. Kernberg recommends assessment of the presence or absence of whole-object relationships, ideals, and the capacity for sublimation and work. Adolescents with borderline personality structure will be far less able to describe themselves or their friends in depth and do not show evidence that they can invest themselves in ideals or goals that have meaning to them (Kernberg, 1978, 1979b, 1982e).

Borderline versus Schizophrenic Conditions. In the absence of clear signs of formal thought disorder, hallucinations, or delusions, the primitive defenses present in both borderline and schizophrenic conditions serve different functions, which can be used in interviewing to make this distinction. In patients with borderline structure, these defenses protect the patients from the experience of ambivalence, and "a feared contamination and deterioration of all love relationships by hatred" (Kernberg, 1975a, p. 179). Schizophrenic patients use splitting and allied mechanisms to prevent "total loss of ego boundaries and dreaded fusion experiences with others" (p. 179), particularly under the stress of

strong affects. This is because persons with psychotic structure do not have clearly differentiated self- and object images. Since primitive defense mechanisms cause ego weakness in patients with borderline structure, interpretations should strengthen the ego and lead to better functioning in the interview—more reflectiveness and attempts at integration and better reality testing. Interpretation of the same primitive defenses in schizophrenic patients reveals difficulty with self-object differentiation and hence leads to regression—more overt primary process or delusional thought, loosening of associations, or paranoid distortions of the interviewer—in response to the interpretations given during the interview. Hence, the interview should be conducted with inquiry into responses which are unusual or subtly inappropriate, to test the patient's defensive functioning.

Transference psychosis, which may be present in both borderline and schizophrenic conditions, is different in each group because of the different mechanisms involved. With borderline patients, the transference psychosis is limited to the treatment hours and responds to Kernberg's recommendations for structuring the treatment. With psychotic patients, their psychotic behavior and lack of reality testing in treatment is for a long time no different from that outside the treatment. Later on, they may feel convinced that they and the therapist are one. This is in contrast to the transference psychosis of borderline patients, who always maintain some sort of boundary, even if they feel themselves to be interchanging aspects of identity with the therapist (Kernberg, 1975a, 1980c).

TREATMENT IMPLICATIONS

Kernberg goes into considerable detail in his diagnostic system because he believes that borderline structure, as well as certain other characterological features of diagnosis, have specific implications for treatment and prognosis. For example, he views dishonesty by the patient as a particularly unfavorable prognostic sign, which might lead to a recommendation for the use of major environmental supports or other modifications in psychotherapy (Kernberg, 1975a). On the other hand, he warns against supportive psychotherapy for schizoid patients. Narcissistic patients with different types of functioning warrant different types of treatment.

RECOMMENDATIONS FOR PATIENT SUBGROUPS

Kernberg recommends expressive psychoanalytic psychotherapy, incorporating his modifications, for patients with borderline personality organization, including patients with narcissistic personality disorder who function on an overt borderline level. That is, the pathological selfstructure in some narcissistic patients is sufficiently stable to allow the patient to function without the impulsiveness, chaotic relationships and general manifestations of ego weakness that characterize borderline functioning. Others, especially those who present with narcissistic rage, function in a manner similar to borderline patients (Kernberg, 1975a, 1980a,c).

For patients with narcissistic personality disorders, Kernberg recommends unmodified psychoanalysis if at all possible. Without the analytic setting, such patients tend to remain shallow, empty, and uninvested in the treatment and do not develop very meaningful transference reactions. Even if they do undertake analysis, however, they may wish to stop the treatment after amelioration of some of their more painful experiences of envy or disruptive impulsiveness, feeling content to remain somewhat shallow and unempathic. At such times, the analyst may need to shift to a partially supportive technique to help the patient maintain a better adaptation by protecting some of the narcissistic defenses when these cannot all be worked through (Kernberg, 1975a, 1979a).

Some cases present the following contraindications for expressive psychotherapy: (1) inability to work verbally with symbolic material; (2) a combination of low motivation and high secondary gain; (3) severe negative therapeutic reaction; (4) severe cases of antisocial personality, so that the therapist cannot assume the patient will be honest even most of the time; and (5) life circumstances that prevent the patient from the frequency of sessions required for expressive treatment (usually two or three times a week). These contraindications can include patients from across the diagnostic spectrum, although the more disturbed borderline, narcissistic, and psychotic patients will fall into the first four categories more often. Such patients should be treated with a frankly supportive treatment, with rational, concrete treatment goals. The therapist should represent a commonsense point of view, making suggestions,

consulting with family members if necessary, and should interpret primitive defenses and conscious negative transference only in the context of showing how these create difficulties in the patient's life. Idealization of the therapist should be discussed only if it interferes with the work, for example, by inhibiting the patient's questions or disagreements. The major focus is on clear life goals. There are some patients who simply need a lifelong supportive relationship, but this alternative should be chosen only after other treatments have been ruled out (Kernberg, 1980e, 1982i, g). Kernberg (1977b) has also discussed indications and technique for brief psychotherapies.

There are two groups of patients who do not do well with supportive treatment, according to Kernberg. These are well-functioning schizoid individuals, who would enter and leave a supportive therapy untouched by the human interaction, and certain narcissistic patients who are lonely, isolated, and empty. These characteristics are unlikely to change without exploration in detail of the primitive defenses and representations of self and others that contribute to the shadowy quality of personality conveyed by these patients. Patients who cannot experience much empathy for others cannot learn to do so without the development of higher-order, more complex representations of self and others interacting. For these patients—narcissistic patients functioning on a borderline level and most patients with borderline personality organization—Kernberg (1980e, 1982d, i, g) recommends his modified, expressive psychotherapy.

RATIONALE FOR TECHNICAL RECOMMENDATIONS

Kernberg proposes that the model of development and psychopathology summarized earlier explains the behavior of severely disturbed patients in various types of treatment as well as processes in the traditional psychoanalysis of healthier, neurotic patients. The structural differences between borderline and neurotic patients cause them to respond differently to classical psychoanalytic technique. Neurotic patients, who have a well-formed tripartite structure, suffer from intrapsychic conflict usually conceptualized as conflict among id, ego, and superego or between conflicting, higher-order, relatively well-integrated identifications that represent various compromise solutions to the basic conflicts. Kernberg (1980b) lays particular stress on this last point, insisting that there is no impulse-defense configuration without an implied object relationship within which these defenses and impulses are expressed. Borderline patients have primitive intrapsychic structures, which have not been consolidated into the tripartite structure but instead have various split-off self-object-affect units, so that these patients have little awareness that the loved and hated object is one and the same. Their defenses are primitive and tend to weaken, rather than protect, the ego; and the superego is close to being an internal persecutor, rather than a depersonified source of values and self-esteem. Id material may be conscious.

In the psychoanalysis of neurotic patients, defenses are interpreted as they are manifested as resistances, with a gradual unfolding of a regressive

transference neurosis, which reveals the conflicts that create the patients' problems. Such patients' defenses may be less than optimally adaptive, but they do protect the ego; hence, their interpretation and undoing represents a stress that only patients with intact ego functions can withstand. Id material becomes available only after considerable work, and impulsive action is brief. As infantile conflicts are resolved, more flexible and efficient defenses come into being.

When borderline patients are treated with standard psychoanalytic technique, the absence of external structure to support reality-testing functions tends to lead to rapid emergence of primary process material, transference psychosis, or, at least, intense early transference reactions prior to the development of any kind of working alliance. Thus, Kernberg (1982d, 1983) feels a need for a clear distinction between psychoanalysis proper and modifications of technique that might be termed "psychoanalytic psychotherapy."

When patients with good ego strength are treated with one of the psychoanalytic psychotherapies, the results are good in terms of behavioral change and alteration in character traits (although not character structure). Kernberg believes this is a direct result of these patients' greater ego strength and capacity to develop a relationship in which they can accept help. However, when borderline patients are treated with a type of psychotherapy that seeks to interpret only certain defenses or to avoid interpretation of the negative transference, the patients' severe psychological problems persist, and a

chronically shallow treatment relationship often develops, with acting out elsewhere in the patient’s life.

In severe psychopathologies, in Kernberg’s (1980b) view, “what appear to be inappropriate, primitive, chaotic character traits and interpersonal interactions, impulsive behavior, and affect storms are actually reflections of the fantastic early object-relations-derived structures that are the building blocks of the later tripartite system” (p. 187). These are not reflections of actual early relationships, in most cases, but of their distorted internalization and continuation in the intrapsychic world without integration into more accurate, complex representations and more mature intrapsychic structures. Ego weakness results from the persistence of the defenses of splitting and of primitive forms of projection, denial, idealization, and devaluation. Thus, pathology is seen as resulting from conflicts and defenses rather than from a deficit.

Kernberg believes that the poor results when borderline patients are treated with psychotherapy are due to the interaction of their pathological structures with the therapeutic techniques. He makes the following argument:

1. Since patients with borderline pathology suffer from ego weakness as a result of their primitive defenses, systematic interpretation of defenses is indicated to strengthen the ego. Interpretation of defenses will not lead to regression, but will aid the patient’s capacity to observe and

begin to integrate the defensively split S-O-A units.

2. Emphasis on developing a positive transference or providing the patient with a benign model for identification does not accomplish its goal with seriously disturbed patients. Borderline patients typically present strong negative, often paranoid, transferences at some point in the treatment as the negatively experienced S-O-A units are activated in the therapeutic relationship. More often than not, they will be unable to identify with the therapist's healthy ego without some interpretation and resolution of their negative transferences. Without this, or with avoidance of negative transference material, the therapist-patient dyad may simply come to be a reenactment of one of the positively experienced S-O-A units, while other parts of the patient's personality are expressed outside the treatment. The treatment is rendered shallow and meaningless and has little effect on the patient's life.

3. Interventions that would gratify some of the patient's transference demands, made with the idea of lessening pressure on the weak ego, fail to help the patient, but rather tend to support the enactment of one side of the patient's conflicts as a defense against a perception of the therapist as evil or devalued. Hence, such interventions contribute to the patient's distortions of the treatment situation. With healthier

patients, gratification of transference wishes is likely to have a more benign effect, as the patient's capacity to use what is good and to identify with a good parental figure is not so distorted (Kernberg, 1980b, p. 194).

4. Since borderline patients present conscious conflicts that may involve primitive drive content, efforts to avoid "deep" material are misguided. The therapist's avoidance of impulses that are conscious and troubling to the patient would tend to reinforce the patient's fear of these impulses and tendency to express them outside the treatment.

Kernberg therefore recommends a modified form of expressive psychotherapy, not psychoanalysis proper, for most borderline patients. Kernberg's suggestions may be summarized as follows:

Interpretation. Interpretation and clarification, rather than suggestion and manipulation, are the major technical tools to be used. Very often, however, the patient's interpretation of the interpretations or other remarks must be explored, and this may often require the therapist to clarify what he or she meant, as opposed to the patient's distorted perception of what was said. Kernberg (1980b, p. 196; 1982g) believes that with these patients, such clarifications will be more frequent than interpretations, thereby giving a different emphasis to the treatment.

Maintenance of Technical Neutrality. To be able to use interpretation, suggestion and manipulation are contraindicated, and technical neutrality should be maintained as far as possible. However, severely disturbed patients are often unable to observe the inappropriateness of their behavior (for example, repeated verbal attacks on the therapist) or may act in such a way as to endanger their lives or the treatment. It may be necessary to structure the treatment or the patient's life. For example, one might forbid shouting at the therapist, beyond a certain point, in a patient who does not seem to be able to reflect in any way on the meaning of this behavior and who, on the contrary, experiences some drive discharge and then seems unconcerned about this aggression. Limiting this behavior would tend to make the patient anxious and might advance the treatment. Or patients may be asked to live in a halfway house or to meet with another professional who would monitor the patient's activities and give advice, freeing the therapist from the need to "take over" in this way so that an interpretive approach could still be maintained. These interventions would be introduced, ideally, as parameters (Eissler, 1953), gradually eliminated, and their effect interpreted as the therapist seeks to return to a position of technical neutrality. Less dramatic deviations will occur in every session, when the therapist has to clarify the patient's distortions of reality and, in so doing, momentarily takes over an ego function and moves away from a neutral position.

Transference Analysis. Transference analysis will be partial because of the need for simultaneous consideration of the patient's life situation and treatment

goals. In addition, genetic reconstructions are possible only very late in the treatment, if at all; earlier transference interpretations should have a hypothetical quality ("You are acting as if you feel I am a cruel father figure whom you anxiously need to placate"), to avoid premature assumptions about the reality of the patient's childhood experience. This is necessary to deal with the many shifting and fantastic S-O-A units activated in the transference, not all of which will represent actual parent-child interactions. This interferes with actual reconstruction; however, over the course of treatment, as these structures become more integrated, part-object relations and part-object transferences should be transformed into more mature relationships and transferences.

Kernberg suggests a face-to-face therapy that adheres as closely as possible to classical analytic technique, within the constraints imposed by the differences that have been noted between psychoanalysis and this type of psychoanalytic psychotherapy. In addition, the therapist should try to clarify the use of splitting and the nature of the various S-O-A units that will be reenacted recurringly in the treatment. When doing this, it is important to focus on both the current reactivation and the one against which it functions as a defense. Thus, even in the course of discussing a patient's hostile transference attitude, the therapist should note other signs of positive feeling (for example, the patient abuses the therapist, but comes faithfully on time to do so)—the more so because such positive attitudes may form the basis for a working alliance. The cognitive aspect of such interpretations is directed at the patient's capacity to develop an observing ego

and does not contribute to intellectualization or rationalization, according to Kernberg. Rather, in primitively organized patients, cognition is close to affect and psychic structures and helps to organize the patient's chaotic experience. In addition, such comments occur in the context of the therapist's attempt to render a confused, distant, or fragmentary patient-therapist interaction a meaningful human experience, even though it may be based on bizarre fantasies in the patient's mind (Kernberg, 1975a, 1979b, 1980b, c, 1982g).

THE THERAPEUTIC STANCE

In psychotherapeutic treatment of seriously disturbed patients, Kernberg suggests, nonverbal aspects of the patient's communication play a larger role than they do in the treatment of healthier patients. Patients with borderline or schizophrenic conditions may manifest nonverbal behavior that is at odds with their remarks as a result of the use of splitting. Or they may express an S-O-A unit through attempts to induce the therapist to play one of the roles in this unit, attempts that may be conveyed through nonverbal means or through the use of words for their emotional effect. Kernberg (1975a, 1977c) recommends that the therapist follow Bion's (1965, 1967, 1970) idea of the analyst as a "container," to try to integrate within himself or herself the disparate elements the patient presents, in order to articulate the patient's current experience and defenses in the transference. The analyst's willingness to tolerate great confusion, fragmentation, and aggression in the patient, while actively seeking to explore it—

thereby conveying an attitude of hope and acceptance—makes possible the treatment of very seriously disturbed patients.

In a similar vein, Kernberg (1976a, 1981a) is a major proponent of what he terms the “totalistic” view of countertransference, in which countertransference is defined as “the total emotional reaction of the psychoanalyst to the patient in the treatment situation” (1975a, p. 49). While advocating the resolution of countertransference reactions, Kernberg stresses the importance of examining one’s reactions for information about the patient, a view characteristic of Kleinian and interpersonalist theories. Kernberg claims that with more seriously disturbed patients, the therapist’s reactions have more to do with his or her general capacity to tolerate stress and anxiety than with the therapist’s neurotic needs. Since the patient often presents a very chaotic picture, the therapist’s attempt to maintain empathic contact with the patient through partial identifications may lead to some regression in the therapist’s ability to function (Kernberg, 1975a, 1977c). Kernberg (1977c, 1981a) also describes very meaningfully the experience of a therapist in a stalemated treatment effort, and offers suggestions for the resolution of chronic impasses.

GROUPS AND INSTITUTIONS

Kernberg’s ideas about hospital treatment and psychotherapy and his creative application of psychoanalytic thinking to psychiatric settings are based on

his views about group and institutional processes. Although less well known, his papers on these topics reflect a deep awareness of the complexities of group life.

ANALYSIS OF GROUP AND INSTITUTIONAL PROCESSES

Following in the tradition of Miller and Rice (1967; Rice, 1965, 1967) and building on the contributions of Freud and the British object relations group theorists such as Bion (1959), Kernberg has sought to apply a psychoanalytically sophisticated open-systems theory to group and institutional processes. He proposes that the tendency for normal individuals to behave and think regressively in unstructured or large groups is due to the threat to personal identity posed by such groups. This threat arises because such groups activate primitive internalized object relations in their members, with associated primitive defenses and intense, pregenital, aggressive and sexual impulses (Kernberg, 1980b).

In order to understand institutional functioning, it is necessary to examine the institution's task, the resources available to it for this task, and the structure of authority and responsibility in the institution. Kernberg (1973, 1975b, 1980c) discusses, for example, three types of problems that prevent the accomplishment of an institution's task: (1) the nature of the task may be unclear or contradictory, or the task may be seen to be impossible when it is clearly defined; (2) the administrative structure, that is, the structure that controls and maintains the

institution's internal and external boundaries, may be unsuitable for the institution's task, or the organization may be structured to meet the emotional needs of administrators or staff, not to perform the task; and (3) psychopathology in the leader or leaders within the institution may hinder the accomplishment of the organization's task.

Kernberg's contributions in this area have focused particularly on the dilemmas of leadership and the interaction between leaders and groups or institutions. The leader is the individual who manages the boundaries of the group—its time, membership, agenda, and utilization of resources—so it can carry out its task. Because groups exist within organizations and consist of individuals who themselves contain intrapsychic structures at different levels of organization, leaders must be aware of boundary issues throughout these levels. In contrast to Miller's (1969) view of systems as hierarchically arranged in, as it were, concentric circles (society, institution, division of the institution, individual, intrapsychic structures, and internalized object relations), Kernberg takes the position that hierarchies in most group situations, cannot be reduced to this one-dimensional model. Usually the leader must control the group's contact with nonconcentric sets of systems that impinge on the group in different ways. In therapeutic settings, in addition to administrative and political pressures on task definition and resources, professional, personal and technical value systems are influential (Kernberg, 1975b). Kernberg suggests that the best way for a leader—particularly the leader of a therapy group or hospital community—to understand

the effect of these pressures and responsibilities on the group, is to observe his or her own emotional and cognitive experience in the group. This view is similar to Kernberg's espousal of the usefulness of countertransference (defined broadly) in individual psychotherapy.

Regressive pressures on staff members in organizations lead to a tendency to attribute the causes of institutional problems to the leader's incompetence or personality, so that the individual may defend against awareness of problems with the institution's task or structure. Organizational pressures can affect the leader's personality functioning, however, and some institutional problems are created by individuals with particular types of psychopathology who actively seek positions of authority. Hence, organizational consultants must combine the ability to define tasks and assess institutional structures with the capacity to assess the personal qualities of leaders from a psychoanalytic perspective (Kernberg, 1980b).

HOSPITAL TREATMENT

Kernberg recommends hospitalization to protect the patient who might otherwise irreparably damage his or her life, career, or relationships and to protect psychoanalytic psychotherapy by allowing the therapist to maintain a position of technical neutrality, aside from the recommendation for hospitalization. This might be necessary with a patient who had the capacity to benefit from an expressive psychotherapy but who also needed external guidance

and support. Hospitalization or a period of residence in a halfway house would then serve to prepare the patient for outpatient treatment in which the patient will take responsibility for his or her own life and would in other respects maintain a therapeutic alliance. Some patients immediately threaten the continuation of their psychotherapy with impulsive behavior, attempts to control the therapist, or attempts to force the therapist to take responsibility for the patient's life. In some such cases, an initial period of hospitalization may help to clarify the patient's psychological strengths and weaknesses (Kernberg, 1975a, 1976, 1981d, 1982b).

The group activities, rules, and regulations and the multiple, new interactions in which the patient must engage in the hospital provide a way to diagnose the patient's pathological internal object relations. The combination of psychopathology in the patient and the many group situations in the hospital allows the patient to replicate his or her internal conflicts in the social field (Kernberg, 1973, 1976). Kernberg (1973, 1975b, 1981d, e, 1982a) gives an outline for hospital administration which provides a structure that maximizes the staff's ability to gather and utilize such data therapeutically. The hospital psychotherapist might then use such data to help patients explore the internal conflicts that are causing them to act a certain way in the hospital. For example, borderline or schizophrenic patients may quickly develop opposite relationships with different subgroups of staff, based on their defensive use of splitting, with the tendency to create in the external world the "good" and "bad" internalized object

relationships that comprise their psychic worlds. Kernberg (1973, 1976) has also provided detailed, sophisticated suggestions on the role of the various modalities of treatment (the milieu, groups, nursing and medical management, activities, and hospital psychotherapy of various kinds, with or without a separation between the therapist and administrator) in the psychoanalytic hospital. Underlying his recommendations is the assumption that unmistakable evidence of the staff's respect and concern for the patient is a crucial element in hospitalization, since patients who are hospitalized are those who do not have sufficient respect or concern for themselves to manage their lives. Ideally, through the hospitalization, the patient will develop a therapeutic alliance that will sustain outpatient psychotherapy. This change occurs, in part, because so many aspects of hospitalization are clearly and realistically helpful, in contrast to the patient's fantasied, transference distortions (Kernberg, 1973).

THE THEORY OF AFFECTS AND DRIVES

We will conclude this summary of Kernberg's contributions with his theory of drives and affects, which in many ways is his most carefully considered theoretical statement. We have already summarized Kernberg's model of the developmental stages of internalized object relations, the final phase of which is the integration of contradictory S-O-A units into complex perceptions of self and other, and the maturation of ego and superego into adaptive structures. We consider Kernberg's theory of drives and affects separately, even though it is

intended to fit into the developmental model, because it represents an additional focus in his work in which he interprets neurophysiological data and reexamines the dual instinct theory (Kernberg, 1976, 1980d, 1982d, h). Kernberg proposes that

> the units of internalized object relations (the S-O-A units) constitute subsystems on the basis of which both drives and the overall psychic structures of ego, superego and id are organized as integrating systems. Instincts (represented by psychologically organized drive systems) and the overall psychic structures (id, ego, superego) then become component systems of the personality at large, which constitutes the suprasystem. In turn, the units of internalized object relations themselves constitute an integrating system for subsystems represented by inborn perceptive and behavior patterns, affect dispositions, neurovegetative discharge patterns, and nonspecific arousal mechanisms [p. 85].

Kernberg (1976) states that by conceptualizing the elements of this theory as subsystems and suprasystems, he avoids proposing “a neurophysiological model of the mind or a mechanical model of body-mind equivalence” (p. 86). Thus, he speaks of hierarchies of organized systems. At some point, however, there is a shift from “neuro-physiologically based functions” and “physiological units,” (which would refer to changes in electrical patterns or neurotransmitters) to the integration of these units into a “higher system represented by purely intrapsychic structures, namely, the primitive units of internalized object relations (self-object-affect units)” (p. 86). These units are themselves eventually integrated into id, ego, and superego.

“Affect dispositions,” which are inborn and determined by brain functioning, constitute primary motivational systems, in that they represent dispositions to the subjective experience of pleasure and unpleasure. These affect dispositions “integrate the perception of (1) central (pleasurable or unpleasurable) states [that is, perception in the central nervous system], (2) physiological discharge phenomena, (3) inborn perceptive and behavior patterns, and (4) environmental responses” (Kernberg, 1976, p. 87). The Freudian concept of instinct may be included here. Affective patterns communicate the infant’s needs to the mother and thereby initiate interactions, which are stored as memory traces with affective and cognitive components. “Affects are the primary motivational system, in the sense that they are at the center of each of the infinite number of gratifying and frustrating events the infant experiences with his environment” (Kernberg, 1982h, p. 907), each of which leads to an internalized object relation, fixed by memory.

Affect and cognition evolve together at first because their respective memory traces are integrated in affective memory (Kernberg, 1976), but eventually differentiation of pleasurable and unpleasurable experiences and of components of self and other takes place. At this point, Kernberg (1982h) asserts, the “good” and “bad” experiences generate the overall organization of motivational systems, which we term love and hate.

Kernberg (1982h) then suggests that love and hate become stable

intrapsychic structures, "in genetic continuity through various developmental stages" (p. 908), which can be equated with the psychoanalytic concepts of the two drive systems, libido and aggression. At this stage of organization, affects serve a signal function for the two drives, and increasingly complex subjective, behavioral, and cognitive elaborations of affects and drives develop. Drives will always be manifested by specific wishes in the context of particular object relations, a phenomenon that is more precisely articulated than an affect state.

Kernberg's (1976) theory deals with economic issues as follows: Variations in the intensity of drives or affects can be attributed to either constitutional variations in the innate components of the system (the hypothalamus, genetically determined behavioral patterns, etc.), or to variations in the environment (the responses of the mother and so forth). Neutralization (Hartmann, 1955) takes place when positively and negatively valenced self-object-affect units are combined to form more complex and realistic self- and object representations with the achievement of the depressive position. Kernberg (1976) writes: "*The synthesis of identification systems neutralizes aggression and possibly provides the most important single energy source for the higher level of repressive mechanisms to come*, and implicitly, for the development of secondary autonomy in general" (pp. 45-46, italics in original). What Hartmann termed fusion of drives is also included, according to Kernberg, in the combination or integration of opposing affects as part of the integration of contradictory S-O-A units. Similarly, sublimation is not simply a change in the use of drive derivatives in an economic sense; it, too, has an

object relations component: Sublimatory activity requires the capacity for some whole, integrated object relationships, some genuine concern for oneself and others (Kernberg, 1975a, p. 134). Nonetheless, despite the importance Kernberg assigns object relations in his theory of affects and drives, he also argues for the importance of aggressive drive manifestations and the biologically based changes in drives, which influence object relations (as in the genital strivings of the oedipal period). Thus, he claims to support the proposition that drives, rather than object relations, constitute the primary motivational system of the organism.

DISCUSSION

We will now offer commentary on the contributions of Kernberg that we have attempted to summarize. Since we are not here comparing Kernberg's positions with those of other analysts, such as Kohut or Brenner, we will restrict ourselves to a critical discussion of Kernberg's clinical and theoretical work.

At the very least, Kernberg has synthesized a good deal of the clinical observations of the object relations school and helped to develop a nosology that orders these observations. Thus, for example, Guntrip's (1968, 1971) or Fairbairn's (1952) observations of the schizoid person fit nicely into Kernberg's conceptualization of one type of patient with borderline personality structure. Kernberg is able to show how some of the writings of Winnicott (1965, 1975), Melanie Klein (1946), Balint (1968), and even Greenson (1954) can be understood

within his concept of the borderline personality. His way of thinking about the levels of severity of character pathology, based in part on object relations concepts, may prove to be extremely useful. In addition, he has integrated the British object relations school's stress on aggression into his clinical and technical writings in a way that helpfully underscores the importance of dealing with aggression, both in clinical situations and in theory development.

We consider it a strength of Kernberg's writings that he frequently relates his theoretical points to observable clinical phenomena. For example, he has not only shown in his attempts at theoretical integration how a variety of authors (Balint, 1968; Fairbairn, 1952; Frosch, 1960; Greenson, 1954; Guntrip, 1968,1971; M. Klein, 1946; Schmideberg, 1947; Winnicott, 1965, 1975) refer to the use of primitive defenses such as splitting and projective identification by borderline patients (using Kernberg's definition of borderline, not necessarily those authors' own), but he has also sought to describe how one might infer the use of splitting or projective identification by a patient in a clinical interview. Similarly, he is willing to claim that practical consequences follow from his theoretical assumptions about diagnosis and particularly from assessment of level of defensive functioning. This willingness to make predictions makes it easier for other investigators to test his inferences and conclusions. As an example, Kernberg is remarkably specific and detailed in relating prognosis and choice of psychological treatment method to diagnosis based on his nosology. A patient suffering from a narcissistic personality disorder, without overt borderline-level

functioning, should be treated with unmodified psychoanalysis; a patient with narcissistic personality disorder who functions overtly on a borderline level should be treated with Kernberg's modified psychoanalytic psychotherapy. The same types of patients might require a shift to a supportive type of psychotherapy at some point in the analysis or psychotherapy, but this would not result in the type of change to be expected from psychoanalysis or from Kernberg's modified form of psychoanalytic psychotherapy. Some narcissistic patients present negative prognostic features (severe antisocial features, conscious enjoyment of others' suffering, chronic absence of human involvement, etc.), which indicate a need for supportive psychotherapy from the onset (Kernberg, 1975a, 1979a, 1980c, 1982g, i).

To summarize at this point, Kernberg's achievements in the areas of clinical writing and observations seem particularly impressive:

1. He has synthesized the writings of a number of authors, particularly those of the British object relations school but also including Jacobson and Mahler, and shown how their clinical observations can be conceptualized in the context of his definition of the borderline personality organization.

2. He has added a number of his own clinical observations and worked out a detailed classificatory system, particularly for character pathology and

the borderline personality, within a five-level structure for describing the full range of psychopathology.

3. He has specified a method of interviewing with stated criteria derived from the interview, through which one can reach complex diagnostic determinations.

4. He has related his diagnostic categories to choice of treatment and to prognostic statements about therapy outcomes.

Kernberg has covered a vast territory in his clinical writings, and he covers it in a systematic fashion. We must join other writers (Calef & Weinshel, 1979), however, in wondering how he is able to make so many prognostic statements with such assurance.[3] His level of specificity is rare in our field and it would be virtually impossible for Kernberg to have personally diagnosed and treated (and treated to the point of termination, in order to substantiate prognostic claims) all the different types and subtypes of patients that are the subjects of his classification system, treatment recommendations, and prognostic statements. Thus, his prognostic statements, for example, must come from a combination of research findings, consultations, supervision, and his experience of being involved in and directing a variety of clinical facilities.

Does Kernberg base his prognostic statements on research findings (Kernberg et al, 1972) from the Menninger outcome studies or on his impressive

clinical experience? It is often difficult to tell, but most often he writes with the assurance and precision of someone who has a great deal of empirical research to buttress his points. He understandably does not give extensive clinical examples, that is, complete case studies, for if he did, given the range of categories and subcategories he discusses, he would literally fill our journals with clinical examples. Though it is beyond the scope of our chapter to evaluate the major outcome research with which he has been involved, we believe that Kernberg would acknowledge that his assurance about all his prognostic statements could not reasonably be based on this research. Moreover, although this research is of great interest, it is by no means free from serious methodological criticisms, which affect the types of prognostic statements Kernberg has made. It is our assumption, then, that a number of Kernberg's statements and recommendations are based on his clinical experience.

Given that this is the case, it is understandable that Kernberg has been criticized (Calef & Weinshel, 1979) for his tone in his clinical writings. He writes as if he has sound evidence for his assertions, but, at least up to this point, he has not fully indicated the nature and extent of his evidence. We join in the criticism that has been leveled at Kernberg in this area, but we wish to note what we believe are two mitigating considerations. First, one can criticize any number of psychoanalytic authors for writing as if something had been "demonstrated," when they were really stating their views based on, perhaps very interesting, but nevertheless limited, clinical observations. Second, unlike the types of statements

made by many other psychoanalytic authors, Kernberg's statements are in a form that makes them potentially testable (although to test his assertions would require a very elaborate and difficult research undertaking).

A number of analysts have criticized Kernberg's clinical concepts on other grounds than those we have noted. Although it is beyond the scope of this exposition to enter into the type of detailed criticism leveled by, for example, Calef and Weinshel (1979) or implied by the type of reconciliation between Kohut and Kernberg attempted by Stolorow and Lachman (1980), we will comment briefly on Calef and Weinshel's critique.

We believe that Calef and Weinshel have brought up interesting and potentially devastating criticisms. They include the ones we have previously discussed, and, most seriously, they cast doubt on the validity of Kernberg's contention that there are people with a *stable* personality organization which he has labeled borderline. (A related criticism, that Kernberg claims premature diagnostic closure in a very complex area, which still needs further exploration, is offered by Sugarman and Lemer (1980). Calef and Weinshel also feel that Kernberg's concepts tend to dilute basic psychoanalytic concepts such as regression, and the very idea of intrapsychic conflict. However, a central point in their critique is their attempt to question the borderline concept itself. They criticize Kernberg for discarding the idea of a continuum that would include borderline and psychotic conditions and for maintaining that conventional reality

testing is either present or absent. Instead, Calef and Weinshel (1979) conclude that "the relativity of reality testing…makes it a difficult area to establish hard and fast, categorical, isolated criteria for the diagnosis of a psychosis" (p. 485) and, by extension, makes it difficult to delineate people with borderline personality organization from people who are psychotic.

With respect to Calef and Weinshel's criticisms, we would comment that many of their points could be framed and tested or could at least be subject to empirical observation. We would hope that if they are serious critics, they would endeavor to spell out the empirical justification for some of their criticism. It hardly seems enough to doubt Kernberg's observations. We are not asserting that they are necessarily mistaken about some of their points, but that, they should attempt, as Stone (1980), for instance, has done, a more clinically and empirically oriented approach to some of their criticism. To criticize Kernberg's categorical formulation of the concept of reality testing, they might offer data that support a continuum approach. Stone (1980) has provided examples of interviews in which assessment of structure according to Kernberg's criteria was extremely problematic, particularly in patients with unusual types of affective illness or in recovering schizophrenic patients, leading him to suggest that reality testing is not dichotomous in all situations. Our criticism of Calef and Weinshel is that at times they seem to come close to simply saying Kernberg is wrong because he is not "psychoanalytic."

This brings us to consideration of criticisms of Kernberg's theoretical endeavors. Calef and Weinshel state that Kernberg's theoretical position is close to, if not actually, a paradigm shift from classical Freudian and ego psychoanalytic theories.[4] Within the limits of their article, however, they do not present convincing logical arguments for their assertion.

The question of Kernberg's theoretical position is taken up more centrally in a paper by Klein and Tribich (1981). In this article, Klein and Tribich are not specifically concerned with the idea of a paradigm shift, but they state that from their point of view, "Kernberg's rapprochement between Freudian instinct theory and object-relations theory obscures the differences between these two competing theories without taking any recognition of their differences" (p. 41). As is the case with Calef and Weinshel (who criticize Kernberg's more clinical positions), Klein and Tribich raise fundamental questions concerning Kernberg's theoretical positions. For example, they maintain that Kernberg's dismissal of "Bowlby, Fairbairn, Guntrip, and Winnicott is not based on any scientific discussion of their theories but on the fact that these theories reject Freudian motivational theory" (p. 41). We will not fully explore Klein and Tribich's criticisms here, but we can comment that we find it strange to maintain that Kernberg rejects all these theories. This in fact is not the case; Kernberg does attempt to integrate aspects of Fairbairn, Guntrip, and Winnicott into his theoretical and clinical writings.

Before discussing more substantive criticisms of Kernberg's theoretical work, however, we would like to expand our introductory comments on the state of psychoanalytic theory and theoretical criticism. As we implied, we believe that much of the work in both areas leaves something to be desired, when considered from the point of view of philosophy of science. Because the standards for criticism typically seem to be so subjective (Ellman & Moskowitz, 1980; Moskowitz & Ellman, 1983), any new psychoanalytic theoretical proposal or integration is vulnerable. We believe this statement applies as we have noted, to some of Calef and Weinshel's comments, and we would suggest that it applies also to some, although not all, of Klein and Tribich's remarks. It can be useful to discuss how one theorist's use of a concept differs from another theorist's, but this does not constitute a criticism, unless one discovers logical fallacies within the system or data that contradict the theory. To criticize Kernberg for differing with Freud, for example, is not a theoretical criticism, but a value judgment.

However, we must also tender this and some other general criticisms in consideration of some of Kernberg's writings. We think that his points would be clearer if he would place greater emphasis on stating his definitions, assumptions, and positions and less on cataloging theorists with whom he agrees or disagrees. The clarity of the presentation of Kernberg's theoretical propositions sometimes suffers from his tendency to give such qualified and complex statements that it becomes difficult to use his theoretical assertions to make definite predictions. In addition, the "catalogs" of theorists give Kernberg's theoretical work somewhat of

an arbitrary feeling, akin to what we believe is an arbitrariness in the writings of some of his critics, which seems to imply, "If you disagree with so and so, then you are not psychoanalytic and, therefore, you are wrong." This type of comment, although all too prevalent in psychoanalytic writings, is not up to Kernberg's standards. We would thus have to agree with Klein and Tribich (1981, p. 39) when they criticize Kernberg's rejection of Guntrip for his "emotionally charged" attacks on instinct theory. Furthermore, we feel that Kernberg does not have a strong position from which to censure another theorist for deviating from classical psychoanalytic instinct theory.

A philosophical approach to the critical review of Kernberg's theoretical contributions would deal with different types of issues. We would wish to examine questions such as the following: How well does Kernberg integrate object relations theory with Freudian theory? Aside from consideration of various psychoanalytic traditions, does Kernberg have a well-integrated theoretical position? And, in a more general sense, is Kernberg's theory a good theory, according to the requirements of theory making such as logical structure, rules of inference, and so forth (Nagel, 1961; Popper, 1962)? We would submit that no psychoanalytic theorist's work could withstand this type of scrutiny. Hence, again, the harsh tone of some of the criticism directed at Kernberg seems unwarranted.

It would be useful, however, to discuss briefly some of Kernberg's contributions from the standpoint of these questions to suggest directions for

further work. We will comment on Kernberg's instinct theory, since he claims that in this work he integrates classical drive theory and object relations concepts as well as newer data from neurophysiological studies. It is thus appropriate to ask how well he succeeds in this theoretical integration. This question is separate from comments about the validity, elegance, or heuristic value of Kernberg's theory and from questions about whether or not it is "psychoanalytic."

In his discussion of instinct theory, Kernberg (1982h) goes over a familiar but nevertheless important point: Freud's term *trieb*, which is usually rendered as "instinct," may more reasonably be translated as "drive." Kernberg is pointing out, as have others (Bibring, 1969; Hartmann, 1964; Holder, 1970; Schur, 1966), that by instinct Freud did not mean a fixed, prewired, behavioral pattern (which is more of an ethological idea). Rather, in his concept of instinct or drive, a variety of behaviors or mental events might emerge as a result of internal stimuli or excitation. Kernberg's substantive attempt is to link or translate Freud's ideas into modern neurophysiological and neurobehavioral concepts. It is, again, beyond the scope of this chapter to discuss fully this aspect of Kernberg's writings, but in summarizing Kernberg's ideas we hope to give a sense of his position and our evaluation of this position.

Kernberg (1976) places affect dispositions at the center of his statements on motivation. He concludes:

> Affect dispositions constitute the primary motivational systems which

> integrate the perception of (1) central (pleasurable or unpleasurable) states, (2) physiological discharge phenomena, (3) inborn perceptive and behavior patterns, and (4) environmental responses as they impinge on specialized and general extroceptive and introceptive perceptions. The earliest "self-object-affect" units are, I suggest, constellations of affectively integrated and cognitively stored perceptions of affective, physiological, behavioral, and environmental changes—perceptions within which the "self" and "nonself" components are as yet undifferentiated [p. 87].

In this passage, Kernberg is attempting to link what he considers to be Freudian psychoanalytic theoretical statements with neurophysiological statements through the use of an object relations perspective. He goes on to specifically include MacLean's (1967,1972) model of three concentric brains as being relevant to the way he conceives of instinct as developing in the human being

> gradually out of the assembly of these "building blocks," so that the series of pleasurable affect-determined units and the series of unpleasurable affect-determined units gradually evolve into the libidinally invested and aggressively invested constellations of psychic drive systems—that is, into libido and aggression, respectively, as the two major psychological drives. In other words, affects are at first primary organizers of instinctive components such as specialized extroceptive perception and innate behavior patterns and, later on, constitute the "signal" activator of the organized hierarchy of "instinctually" determined behavior [pp. 87-88].

These two quotes give a reasonable flavor of the complexity and direction of Kernberg's ideas on instinct. We believe that, in fact, his theoretical compilation places him substantively closer to Bowlby (1969, 1973,1980) and perhaps even Fairbairn and Guntrip than to Freud. Central to Freud's (1915) ideas about

instinct is the formulation that it is generated internally and that the instincts appear “as a constant force” (p. 119). Nowhere in Kernberg’s writings do we see this essential aspect of Freud’s concept that instincts provide a form of constant internal stimulation that makes substantial demands on the nervous system. To quote Freud (1915):

> Instinctual stimuli, which originate from within the organism, cannot be dealt with by this mechanism. Thus they make far higher demands on the nervous system and cause it to undertake involved and interconnected activities by which the external world is so changed as to afford satisfaction to the internal source of stimulation. Above all, they oblige the nervous system to renounce its ideal intention of keeping off stimuli, for they maintain an incessant and unavoidable afflux of stimulation. We may therefore well conclude that instincts and not external stimuli are the true motive forces behind the advances that have led the nervous system, with its unlimited capacities, to its present high level of development. There is naturally nothing to prevent our supposing that the instincts themselves are, at least in part, precipitates of the effects of external stimulation, which in the course of phylogenesis have brought about modifications in the living substance [p. 120].

We have included this long quote from Freud in an attempt to capture what we believe is a subtle but nevertheless important difference between Freud and Kernberg’s concept of instincts. Certainly from at least 1915 on, Freud stressed the internal or endogenous nature of the instincts, not only as a motivational concept but also, in higher-level organisms (particularly primates), as a system that stimulated the development of the central nervous itself. Thus, the infant’s and child’s task of “mastering” internal or endogenous stimulation is in fact a central task. Clearly, environmental factors can make this task easier or harder,

and clearly the environment is important in development, but the “constant pressure” of endogenous stimuli will be there regardless of the type of “instinctual building blocks” that are present in the infant’s environment. If we take Kernberg seriously in his attempted neurophysiological integration, then he is moving toward more of an environmentalist position than Freud held. By and large, Kernberg does not see endogenous stimulation as a central concern. Hence, in this area of his theorizing, he has not really integrated Freud’s position into his own.

We would say that, in general, Kernberg has not fully integrated the various positions he uses; that critics (Calef and Weinshel, Klein and Tribich) appear from both sides of the controversy between Freudian and object relations theories is consistent with this view. At times, Kernberg merely places together different theoretical positions rather than integrating these positions, for example, by showing how a particular definition of a concept adds to the power of the theory. Similarly, he often presents his selections among possible points of view without giving the clinical or logical justification as to why he has chosen certain positions and not others. It is never really clear that additional explanatory power is gained by combining object relations and Freudian (or ego psychological) concepts.

This brings us to a related logical criticism. Given that he has selected and defined certain concepts in the formation of his theory, Kernberg provides little in the way of theoretical or logical structures (rules of inference) to show how his theoretical positions link together in an overall theoretical system. For example,

he might begin to provide rules that would predict under what circumstances active splitting replaces passive splitting and develop criteria independent of the theoretical concepts to test the predictions implied by such rules. At this stage, he does not clarify the explanatory power of his theory. To put this in another way, he does not show what the developmental, affect, or instinctual aspects of his theory really add to our understanding of his clinical and nosological observations and conceptions. In a sense, to use Rubinstein's (1967) term, his theory often seems to be "merely descriptive." Although this is not necessarily a criticism, Kernberg obviously aspires to something more. Yet often he does not show how this theory is more than a plausible restatement of his clinical points.

We have been critical of Kernberg in the latter part of this review, but we reiterate that these criticisms follow from the application of standards that, in our opinion, no psychoanalytic theorists could meet. We have expected Kernberg to present a full-blown theory of the kind that not even Freud managed to produce. Moreover, if Kernberg has not carried out the type of theory building or logical analysis that would enable him to present more convincing arguments, neither have his critics. One must sympathize with Kernberg to some extent, since his task is the harder one and since he has, at times, attempted to alter or clarify his positions in response to points raised by critics.

In conclusion, we would say that Kernberg has raised fundamental issues and, more than any other contemporary writer, he has pursued these questions

with vigor and insight. The answers he proposes are among the most interesting presented by today's psychoanalytic theorists. He is also one of a relatively small number of psychoanalytic thinkers who devote considerable attention to research issues and findings (Carr, Goldstein, Hunt, & Kernberg, 1979; Kernberg, 1981b; Kernberg et al., 1972). Despite our critique, we are impressed with Kernberg's attempts to develop a comprehensive and systematic theory of development, psychopathology, and treatment, and he must be considered a major psychoanalytic theorist. In many areas, one cannot begin to formulate appropriately a problem without referring to Kernberg's work. That is, by itself, no small achievement.

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Notes

1) In this chapter, we will use the terms "instinct" and "drive" interchangeably. Either term refers to Freud's more flexible use of the term *trieb*, as opposed to the ethologist's use of "instinct" as equivalent to a physiological process resulting in a fixed action pattern or a stereotyped behavior pattern.

2) Kernberg adopts Jacobson's (1954) definition of refusion, as attempts to maintain absolute gratification through fantasies that the self and object are merged, fantasies that ignore realistic differences.

3) Although in one recent paper Kernberg (1982i) notes the necessity for caution in such statements and urges further research, the preponderance of his writings imply greater surety about these matters.

4) We are considering the psychoanalytic version of ego psychology or the structural view as part of the classical theory.

About the Author

MONICA CARSKY, Ph.D., is Instructor of Psychology in Psychiatry, Cornell University Medical College, and Staff Psychologist at the New York Hospital-Cornell Medical Center, Westchester Division. A graduate of Swarthmore College, she received her Ph.D. in clinical psychology from the City University of New York. She completed an internship at Bronx Psychiatric Center, Albert Einstein College of Medicine, and a postdoctoral fellowship at the New York Hospital-Cornell Medical Center, Westchester Division, and is currently a student at the New York Center for Psychoanalytic Training.

STEVEN ELLMAN, Ph.D., is Professor and Director, Clinical Psychology Doctoral Training Program of the City University of New York.