

Narcissism and Borderline States: Kernberg, Kohut, and Psychotherapy

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The post-Freudian era of consciousness is examined, wherein the individual is reconsidered from two viewpoints—narcissism and borderline states—via two seminal thinkers, Kohut and Kernberg. This is elaborated on through discussion of a “conflict” in Freud’s work (i.e., the paradoxical conflicts in Freud between personal insight and natural science metaphors) and the utilization of paradigm shift and crisis in science. This continues in the dialectic concerning the theoretical and treatment styles of Kohut and Kernberg. The advantages, liabilities, and linguistic structures of both writers are studied in relation to their explorations of disturbances of the self.

Despite their immense growth as two formerly parochial professions, psychiatry and psychology have grown into one industry that is now called mental health. One aspect of it, once predominant and now, paradoxically, in eclipse and in renaissance, has been the broad field of psychoanalysis. It has not only brought in an age of psychology, but it has had import on the literary, social, and political fabric.

Like Gaul, the eras of consciousness (Fine, 1978) can be divided into three parts: the Freudian era, the neo-Freudian era, and the post-Freudian era. The first era was the most revolutionary, and, despite its detractors, has been popularized. The other two eras have been little understood, least of all where it may count the most, by a nation’s intelligentsia, who weave it into the texture of their *weltaunschung*. Our paper refers to a part of the third era, the post-Freudian, where the individual is reconsidered from two viewpoints—narcissism and the borderline state—via two seminal thinkers.

Narcissism is often used as a general term for the feelings a person has for himself. *Borderline* is a general term for the severe disturbances of emotional life that are not neurotic, but not severe enough to be called psychotic. Heinz

Kohut (1971) and Otto Kernberg (1974, 1976) are among the foremost writers on the study and clinical treatment of severe emotional disorders involving disturbances of the "self."

Comparing the work of Kohut and Kernberg is a complex task, of which only the bare essentials can be presented in a short paper such as this. The material at hand tends to be difficult to understand, and one of the best ways to clarify it is to temporarily step outside the texts themselves in order to place them in the perspective of the larger context of which they are a part. The first part of this paper is devoted to a presentation of the complex "setting" in which Kohut and Kernberg are to be found, which then leads into an outline of the common ground that the two men share. Then, their disagreements are presented, followed by an attempt to elaborate on some of the implications of their conflict in the context of the larger setting presented initially.

The Kohut/Kernberg controversy is taking place at the leading edge of one of the major developmental lines of theory and practice in psychotherapy, that of psychoanalysis. Both men are trained as analysts and base their work on the psychoanalytic method. The additions, refinements, and revisions, which they have built on a fairly orthodox analytic base, grow directly out of Freud, via the advances made in psychodynamic thinking by the innovators in ego psychology and object relations.

The ego psychology/object relations branch of the psychoanalytic tree has its own particular essence, which tends to tie it, at least loosely, with other intellectual trends outside psychoanalysis. Guntrip (1973) speaks of that particular essence in terms of a specific theme found in parts of Freud's work, which is distilled, refined, and brought to fruition in the elaborations of ego psychology and object relations. Guntrip is referring to the personal, truly psychological insights concerning the subjective human experience, the intimate interactions between people, and the ways in which one relates to oneself that are woven into much of the fabric of Freud's work. Guntrip contends that this deeply personal element is in radical conflict with another element found in Freud's work, the mechanical, reductionistic metaphors based on his 19th-century natural science training. Guntrip sees the development of what is seen as Freud's continually changing theories as a playing out of this conflict toward a gradual, as yet unfinished, resolution in the direction of expressing the elements of personal insight and self-understanding. Object relations, according to Guntrip, is the most recent unfolding of this trend. Guntrip mentions that this conflict in Freud's work can be understood analytically in terms of resistance to self-understanding; that is, the narrow context and language of natural science in Freud's day functioned as resistance in Freud's personal and interpersonal insights.

Guntrip's (1973) overall view of this conflict in Freud's work can be elaborated to encompass the work of Kohut and Kernberg, so as to render their controversy more understandable. Before embarking on this elaboration, we

must return briefly to the previously mentioned intellectual trends outside psychoanalysis, which flow into the stream of object relations and ultimately relate to the work of Kohut and Kernberg.

When Guntrip (1973) refers to the component of personal understanding in Freud, he is thinking of object relations, as well as its psychoanalytic heritage, as the science of the self. However, there is another science of the self: phenomenology and its elaboration in the form of existentialism. To the extent that phenomenology and existentialism come at the same issues from different angles, some of their general emphases can broaden our perspective on object relations and the Kohut/Kernberg controversy.

Phenomenology attempts to create a pure, straightforward method of studying ourselves, and existentialism attempts to apply it to the realities of human living. One of the important features of this intellectual development is the concept of using a clear, simple, and direct language to elaborate our understanding of our experiencing as selves. A brief look at any text by Merleau-Ponty or Heidegger suffices to demonstrate that, in reality, the pioneers of this approach created a highly technical and complex language. Many academicians, as a result, have devoted themselves to the reexpression of these authors' ideas in clearer language more accessible to the nonexpert.

It is not insignificant that we can, in passing, make precisely the same observation regarding Kohut and Kernberg. Their works represent an advance over Freud's oftentimes obfuscating language system, and yet their own texts are the object of extensive secondary elaboration by commentators who often present a picture of confusion and disagreement among one another. This is not to say that Merleau-Ponty, Heidegger, Kohut, and Kernberg have failed to develop more straightforward language. On the contrary, in every case, a major component of these writers' contributions has been an advance in the area of clearer terminology. The extreme difficulties in comprehension experienced by their readers, however, attest to the inherent difficulty of the material and the matters with which they deal.

It is difficult to arrive at a penetrating understanding of ourselves without becoming ensnared in the difficulties of expressing ourselves verbally. And an awareness of this fact is a critical precondition to overcoming this language barrier. This awareness of language as a problem in the work of self-understanding is the special contribution of phenomenology and existentialism. The direct fruition of this contribution in the realm of psychoanalysis is exemplified in Van den Berg's (1972) elegantly wrought reworking of basic Freudian concepts into a simply stated framework of phenomenological terminology in his book, *A Different Existence*. In order to go beyond the language barrier surrounding the insights of Kohut and Kernberg, we must extend our understanding of the technical language so that it becomes less of a barrier, so that we can understand the role this verbal wall has played in the creation of scientific ideas.

We began the task of formulating an overview of the context in which Kohut and Kernberg are set by labeling their work as recent advances in a line of inquiry starting with Freud and developing via ego psychology and object relations. We characterized this line of inquiry in terms of Guntrip's (1973) idea of a core of personal insight and understanding of the self grappling with impersonal, mechanistic, obfuscating modes of thought and expression, which he likened to the patient's resistance to insight in clinical psychoanalysis. We then followed the theme of personal insight and understanding of the self to a discussion of phenomenology and existentialism, where we came upon the issue of technical language as both a barrier to and a means of understanding. This brings us back to the paradoxical conflict that Guntrip sees in Freud between personal insight and counterproductive metaphors. We will now discuss this matter in relation to Kohut and Kernberg.

The vehicle of our elaboration and discussion is the engaging philosophy of science developed by Thomas Kuhn (1962) in his book *The Structure of Scientific Revolutions*. After a thorough and detailed examination of the data of the history of science, Kuhn contends that the development, elaboration, and ultimate demise of scientific ideas tend to closely follow specific patterns. According to Kuhn, science begins with perception. People perceive images of objects in the world around them and represent these images of the world in the form of data. Data are representations of observations; for example, numbers represent measurements. As data accumulate, people try to make sense of the collected data by understanding them as parts of a coherent whole. This understanding takes the form of a theory to explain the data. In order to arrive at a unified theory, it is inevitably necessary to make a set of assumptions that define the boundaries of the whole of which the data form a part and the basic characteristics of the whole that render the data understandable.

This set of assumptions, which define the boundaries and characteristics of a science, is called a paradigm. A paradigm is a product of human imagination and is a solution to the puzzle, "How do these data fit together?" A paradigm also defines the boundaries of the puzzle and delineates empty spaces where as yet unfound pieces will fit to complete the puzzle. Thus, a paradigm raises unanswered questions and suggests further avenues of inquiry. This state of affairs is called mature science and is based upon a paradigm system, which contains one critical element in addition to data and theory. That element is method. Method provides the tools and techniques that are applied to the task of further observations, and, thus, generate new data. At first, the new data reinforce and refine the paradigm, but, as the methods are applied, the methods themselves are refined and, thus, generate radically new data.

As these ever-new data accumulate, some of the data are inevitably anomalous; they cannot be explained by the paradigm as it stands. As refined methods provide excursions into new areas of observation, anomalies accumulate. At first, the paradigm can be modified to accommodate anomalies. But, as

the anomalous data require more and more changes in the paradigm, the paradigm becomes more complex, obtuse, unwieldy, and full of additional terms. The paradigm becomes less useful, and alternative competing paradigms are suggested, creating a paradigm crisis.

At this point, the mature science is dead, and there are competing schools of thought that can't really communicate with each other: they disagree on the boundaries of the field of inquiry, on what data are relevant, and on what methods are appropriate. When one of the new paradigms becomes unanimously accepted by the community of scientists (the basis of that acceptance is quite variable), a scientific revolution, or paradigm shift, has occurred and the cycle of mature science repeats itself.

A simple example from the history of science is Ptolemaic astronomy, wherein the earth was conceived as the center of the universe. This paradigm was based on the observation that the heavenly bodies rise and set, and led to various methods of astronomical observation, data collection, and record keeping. With technical refinements of such instruments as the astrolabe and telescope, data that didn't fit the Ptolemaic model were collected. After many attempted modifications and alternative paradigms, Copernicus conceived of his revolutionary model of the solar system.

It is clear that that which Kuhn calls a paradigm is a conceptual entity. A paradigm is a set of ideas, and it is manifested in the form of language. Not only is the paradigm itself expressed in language, but it is also one of the main forces that shape the total language system used by a community of scientists. The paradigm sets forth the critical terms of a science, and it colors the whole field of disclosure within a science by defining the realm of facts, ideas, and actions appropriate to that science. Kuhn's approach to science in terms of paradigms deals not only with the linguistics of science but, in a larger sense, with the psychology of the scientist. In fact, Kuhn's ideas form a paradigm of their own, which can be seen as epistemology, or cognitive psychology, or even a crude kind of general psychology.

Concern for the psychology of the scientist harks back to Guntrip's (1973) concern about resistances in Freud's writings. In both cases, an important part of the problem is confused language. For Kuhn, mature science uses clear, simple, unified language, and science in a state of paradigm crisis uses a confusing melange of contradictory, fragmented, and complex languages. Psychology in the 20th century has been and is in a state of paradigm crisis characterized by competing schools, such as psychoanalysis and behaviorism, which exist in virtually different universes of discourse. This stems from the difficulty of the subject matter, which, as yet, admits no clear and easy paradigm, but leads instead to cumbersome paradigms riddled with symptomatic terminological problems.

Within the general paradigm of psychoanalysis, there have been a number of small paradigm crises resolved by specific modifications of the theory (e.g., Freud's introduction of the structural model in addition to the

topological model) and by splinter groups away from the mainstream with their own separate paradigms (e.g., the Jungian group). The work of Kohut and Kernberg deals with a particular paradigm crisis in psychoanalysis. Kernberg takes the approach of staying within the old paradigm and making as few changes as possible to accommodate new data, focusing instead upon major modifications of method and therapeutic technique. Kohut takes the approach of introducing a whole new paradigm, albeit one that can be subsumed under the old paradigm. The result is that Kohut's theories and methods are much simpler than Kernberg's. Ironically, this permits Kohut to be a methodological purist, using the simplest, time-tested therapeutic approach.

Kuhn's (1962) system was referred to earlier as "crude psychology." In a way, it resembles object relations, treating as it does the perception of objects and their representations (as data) in the context of a structured whole, the paradigm. However, in object relations, the word "self" is substituted for "paradigm." There is a relationship between the self of the scientist and the paradigm that he creates. The paradigm is an expression of the self. Differences in the paradigms used by Kohut and Kernberg express personal differences between the two men, as well as stylistic differences, which come out in their writings, their therapeutic techniques, and the interpersonal style with which they relate to other people, including their patients.

The paradigm of psychoanalysis is based on the concepts of unconscious mental phenomena and internal psychic structure. There are basic assumptions that explain many data and are elaborated upon in the various theories of Freud and post-Freudian analysts, including the proponents of ego psychology and object relations. The primary method of psychoanalysis is free association in the context of the clinical treatment of patients suffering from mental disturbances. The critical data compiled using the method of free association are transference distortions by neurotic patients, in which their perception of the analyst is based upon psychosexual developmental fixations (especially those related to the Oedipal complex), and resistance to the full elaboration and working through of these oedipal transference distortions.

The first and foremost anomaly in the psychoanalytic paradigm was discovered by Freud himself. That anomaly consists of the data that indicate that there is a group of patients who, when allowed to free-associate, do not form a neurotic transference and, apparently, are unable to form a stable, coherent image of the therapist as a whole person, distorted or not. This group of patients consists of those suffering from psychoses. Thus, the ultimate unresolved problem, both theoretical and clinical, facing psychoanalysis is to arrive at an understanding of, and thus a cure for, the psychoses, especially schizophrenia.

Further study of the population that does not form neurotic transferences has, in the past 20 years, unearthed more anomalous data. It has been found that not all of these people are psychotic. Because they are neither neurotic

nor psychotic, they have been called borderline, but in the past this has been a vague category. Kohut and Kernberg are concerned with differentiating the characteristics of this patient group and refining the description and taxonomy of this area of psychopathology. The work is still in progress, and there is as yet no comprehensive description and theory to account for all of these patients. Despite wide areas of agreement, there are many unanswered questions, areas of disagreement, and differences in the systems of categories used by Kohut and Kernberg. We will begin by looking at the basic common ground, then the theoretical differences and disagreements, and, finally, the differences in therapeutic technique.

There are several agreed-upon characteristics of borderline patients. They tend to have pan-neurotic symptoms; that is, they present the symptoms of more than one neurosis at the same time, such as phobias, along with obsessive and compulsive symptoms and/or anxiety, depression, impulsivity, and so on, in an incoherent mixture. Another common borderline characteristic is polymorphously perverse sexual behavior or stable, specific perversions. These patients often present addictions and other disorders of impulse control and frequently complain of identity diffusion. Borderline patients also experience difficulties in the area of object relations; they lack deep, stable, gratifying relationships with other people. This difficulty involves problems of object constancy: Other people are not experienced as dependable, stable individuals, and relationships cannot be relied upon to endure. There is often a disturbance in the functioning of empathy, including the intrusion of internal feelings into the perception of other people, so that others are perceived in a distorted, affectively overdetermined manner. The internal processes whereby feelings and impulses are modulated, managed, channelled, and controlled tend to be disturbed, with resulting excesses of either uncontrolled experiences of intense and primitive affect or overly constricted emotions and extremes of either impulsivity or inhibition of action.

The question of the relationship of borderline pathology to psychosis raises the issue of reality testing. In the past, there was some confusion of borderline patients with prepsychotic or incipiently psychotic patients. Today, borderline pathology is seen, for example, by Kernberg, as a more stable personality organization. It is possible for borderline patients to become psychotic, but, in a natural environment, this is a temporary phenomenon. The person goes in and out of psychosis as the process of reality testing is adversely affected by internal or external stresses.

A related issue is the question of the borderline patient's potential to become chronically schizophrenic. Kernberg sees a potential in some cases for the destruction of the borderline's stable adaptation by what he considers inappropriately regressive psychotherapy. Kohut does not seem to deal specifically with the category of patients to which Kernberg is referring. This gets into a somewhat confusing terminological issue, which will be dealt with

later, but there seems to be agreement that the narcissistic disturbances do not deteriorate into chronic schizophrenia. There also seems to be agreement on the existence of a continuum of borderline pathology from the severe, nearly psychotic "low level," to moderate, nearly neurotic "high level."

Moving from description to analysis, Kohut and Kernberg agree on the basic tenet that oral conflicts, rather than oedipal conflicts, are the basis of borderline pathology. Because the oral stage is the first period of life and precedes the anal and oedipal stages, oral pathology represents a more primitive and undifferentiated adaptation than the relatively mature neurotic adaptation based on oedipal conflicts, wherein oral conflicts are more successfully resolved.

The basic issues involved in the oral state concern the maturation of the baby's crude, subjective experiencing of the world from an undifferentiated fusion into one omnipotent whole, to the baby's development of a self experienced as separate from the rest of the world and its inhabitants. In the undifferentiated state, there are only two affects: total bliss and total dysphoria, or primal depression. There is no sense of time, continuity, or variety in a self or a world, only a discontinuous present. Only after the infant has begun to differentiate himself from others and the world can he begin to deal with his dependence upon others, his autonomy from others as a separate being, or his shame or pride in relation to others. These are the so-called anal issues that, if adequately resolved, can lead to the growing individual's confrontation with the more mature interpersonal issues of conscience and empathy that are entailed in the oedipal struggle and resolved by guilt and identification with the same-sex parent.

In borderline patients, the capacities that develop in the anal and oedipal periods tend to be weak or absent. There are problems of autonomy and the control and channelling of impulses. There is impaired superego functioning, either too lax or sadistically strict, instead of a modulated conscience based on a realistic sense of morality and empathy with others. The centrality of oral conflicts for borderline patients can be seen in the relative fragmentation and discontinuity of their interpersonal relationships, expressed in a lack of constant, deep relations with others. Primitive, undifferentiated feeling states of well-being, agony, and rage intrude upon the realistic perception of people and the world. If this configuration of pathology rooted in oral conflicts is intensified and predominant to the point that reality testing fails and the experience of the self is regressed to a completely fragmented, discontinuous, disoriented state, the person is psychotic. However, borderline patients can experience themselves as intact selves, although the basic oral issues of permeable interpersonal boundaries, object constancy, fear of abandonment, dependency, and impotent dependent rage are experienced conflictually. In affectively neutral situations in which these issues do not play a part, especially situations in which intensive relations with other

people are not involved, the borderline person can function adequately and may even display a high level of intelligence. When the situation creates interpersonal stress or evokes oral conflicts, his functioning deteriorates into the more primitive, pathological state characteristic of the borderline condition.

So far, we have sketched roughly the clinical realm of borderline pathology in loose, psychodynamic terms. Kohut and Kernberg would probably agree more or less with the vague overview. However, they articulate their own descriptions and analyses of borderline pathology in different terms. They use two different conceptual frameworks, and it is difficult to establish points of agreement and disagreement because they speak in different systems of technical language. The two different approaches will be briefly sketched.

Kohut reformulates the sequence of human development in terms of the development of narcissism. Narcissism is defined as the libidinal cathexis of the self. The Freudian metaphor is somewhat difficult to understand, hinging as it does on Freud's concept of instinctual energy, or "libido." Freud described the first state of the instinctual "economy" of the newborn as primary narcissism, wherein all libido was narcissistic libido; that is, all libido was cathected on the self. This is a way of expressing the diffuse, undifferentiated experience of unified omnipotence characteristic of the newborn, in which there is no experience of any nonself. Freud presumed that the libidinal economy gradually differentiated into two modalities, that of narcissistic libido (cathected to the self) and that of the object libido (cathected to external objects).

Narcissism, the libidinal cathexis to the self, may also be understood as the subjective interest in and experiencing of the self. At first, this is a diffuse, all-encompassing experience. Before it develops into a differentiated experience of separate selfobjects and non-selfobjects, according to Kohut, it goes through a transitional stage. In this transitional stage, the infant (roughly 1 year old) experiences separate objects, but he experiences them as differentiated parts of himself; that is, he cathects objects with narcissistic libido. These transitional objects are called selfobjects. Once selfobjects are solidly differentiated, the first step in the differentiation of a cohesive self has been achieved. This step can be a critical and lasting achievement, bearing directly on the future sanity of the individual.

Narcissism develops gradually throughout infancy and early childhood along two separate but parallel tracks of development that correspond to two precursors of later images of the self and the other person. The first track concerns an image of the self called the grandiose self, and the second track concerns a self object called the idealized parent imago. The development of narcissism moves gradually from an archaic state of fusion of the self and the other to the differentiation of the self from the other. The grandiose self and the idealized parent imago represent the first distinct differentiation and form of the foundation upon which further differentiation of the self is built.

These two primitive representations of the self and the other are critical for future mental health in the child because they are basic to the central issue of experiencing oneself as a self of which one is conscious. Self-consciousness is the basis of being a person in an active relationship with one's self and in relationships with other people. The process of interpersonal relations, or object relations, is of primary importance to a self living in relation to a peopled world.

In the first stage of the development of narcissism, called autoerotic fragmentation, the self and the parent are fused into an undifferentiated, fragmented melange. As the child experiences frustrations (e.g., hunger) in this state, he develops an ability to reconstruct the euphoria of the nonfrustrated autoerotic state by forming a grandiose and exhibitionistic image of himself (the grandiose self) and a perfect, omnipotent selfobject (the idealized parent imago). The images begin as fragmented nuclei and gradually develop into clear representations. The child expresses two overriding needs: a need for attention (the grandiose self) and a need to merge with a powerful other (the idealized parent imago). As development proceeds, the adult arrives at a stage of healthy narcissism, in terms of self-esteem, self-confidence, and admiration of others.

If a person has not solidly established the grandiose self and the idealized parent imago, he will suffer from either borderline or psychotic pathology. Kohut uses the term "borderline" more specifically than it has been used so far in this paper. So far, it has been used loosely to mean "neither psychotic nor neurotic." Kohut uses borderline to refer to a subgroup of this group, who, along with psychotics, are unable to establish a transference in psychoanalysis and thus are unanalyzable. These people are unable to maintain a stable, differentiated self in the face of autoerotic fragmentation.

There is, however, another class of people who have solidly established images of the grandiose self and the idealized parent imago, and, thus, have a stable self, which maintains itself against regressions to autoerotic fragmentation. This class of people includes healthy people and neurotics whose pathology is based in oedipal conflicts and who form neurotic transferences in psychoanalysis. The group also includes another subgroup, called narcissistic personality disorders, who have not developed to the neurotic level and do not form neurotic transferences. They do, however, form special types of transferences, which include idealizing transferences, in which the therapist is perceived in terms of the idealized parent imago, and mirror transferences, in which the therapist is experienced in terms of the grandiose self. These narcissistic character disorders (NCDs) can oscillate on the regressive continuum to the point that they closely approach a psychotic state of autoerotic fragmentation. However, this is temporary and highly situation-specific, and they are able to rebound from it. Such regressions put NCDs in a special theoretical position. They are a sort of window on the psychoses because they are verbal people in direct contact with a preverbal state.

Kohut's primary concern is the psychoanalytic treatment of NCDs, who, though not borderline in his terms, fall into our looser category of borderline, and his clinical concerns require that he answer a critical, practical question. If NCDs are treatable by psychoanalysis, and all other borderlines, whom they resemble a great deal, are not analyzable, how does one know when one has an NCD? This is a question of differential diagnosis, and Kohut states that the only one way to answer it is by trial analysis. When an apparently borderline (in the loose sense as defined earlier) patient presents for diagnosis and treatment, Kohut's system requires a trial analysis of at least 6 months. If a stable narcissistic transference develops, that is, either a mirror transference or an idealizing transference, then the patient is an analyzable NCD. The analysis proceeds through the technique of free association to regression, which is likely to include the severe regressive oscillations mentioned earlier, to an elaboration and working through of the transference relationship. This is a very long and arduous process in which the therapist must work with great patience and relative reticence. His role, as in any other psychoanalysis, is to accompany the patient on his regressive journey and interpret the transference.

To get more of a feel for Kohut's analytic technique with NCDs, we must look more closely at the two types of narcissistic transferees. The meaning of the term idealizing transference is self-explanatory. In an idealizing transference, the patient idealizes the analyst and perceives him as an extremely powerful selfobject. The question is, why does the patient relate to the analyst as though the analyst were a very powerful part of himself? The answer is that this kind of person is missing something in himself; he is suffering from a narcissistic vulnerability. Just like the toddler, he has a self that he experiences as a discernible entity, but he has not yet developed the psychological equipment to protect his self-esteem, to protect him from being hurt in this state of narcissistic vulnerability, and to protect him against narcissistic injury. In order to do this, the patient invests the analyst with great power; he then takes this powerful object into himself in the sense of experiencing the self-object as a part of the self. In this situation, the analyst provides the missing function for the patient and protects him against narcissistic injury. The patient, meanwhile, gradually develops the ability to protect his own self-esteem and to perceive the analyst realistically as a whole person separate from himself. Developing this new ability requires the development of a new psychic structure through what are called transmuting internalizations of elements of the analyst's psychic structure.

Mirror transferees can vary along a regressive continuum from the merger transference, which is just this side of psychosis, to the true mirror transference. In between these two poles lies the twinship transference. In the true mirror transference, the patient uses the analyst's response to him to define himself, paying particular attention to the analyst's affective state. Returning to our analogy of the toddler, the patient is at the point where he is aware of

the existence of many objects in the world, of which his self is one, but, like the toddler, he has not differentiated himself sharply enough and therefore does not have the apperceptive equipment necessary to focus his own interpersonal perception onto himself as an object of observation. He is not able to respond directly to himself and give himself definition. For this psychological function, he relies instead upon the functioning of the more mature and differentiated other, the analyst.

The narcissistic distortion is that the patient perceives all of the analyst's emotions, behaviors, and affective states as responses to himself and then perceives himself in terms of the analyst's responses. Again, the analyst must provide this function so that the patient can gradually develop, through transmuting internalization of a new psychic structure, the independent ability to perceive himself directly. Once this structure and the attending independent function are developed, the patient can begin to free others of the burden of his own self-perception. The others, including the analyst, are experienced by the patient as separate selves with their own affects and responses, which may or may not be in response to the patient. This development leads to the task of interpersonal reality testing, whereby the objects of different responses are differentiated in the self and other so that a judgment can be made as to whether or not another person is responding to one's self.

Developmentally preceding the true mirror transference is the twinship transference, in which the patient experiences the analyst as being just like himself. Here, the differentiation is cruder, but it is still possible for the patient to borrow the analyst's psychological functions for his needs. In a merger transference, the patient is approaching a psychotic level of fusion of self and objects, confusing himself and the analyst. At this point, the therapist's functions of boundary maintenance and constancy are needed by the patient to maintain the boundaries and the constancy of the grandiose self. The analyst must define the boundaries between himself and the patient, as well as the spatial and temporal boundaries of the framework of the therapy relationship, so that the patient can gradually decrease the permeability of his own boundaries.

Kohut's analytic technique creates a specific atmosphere. The emphasis is on the transference, on the patient's experiencing of his relationship with the therapist. Rather than emphasizing resistance and the patient's defenses against internal conflicts, Kohut emphasizes the patient's adaptive needs and the development of functioning to adapt to reality and creatively express the self through the media of healthy narcissism. The treatment is based on the curative force of the natural growth process, which is fostered by safe and secure, yet deep and intensive, regression, in the company of the analyst, to the points of developmental stunting. Healthy development depends on healthy transactions with objects in the infant's environment, so corrective growth can only occur by going back and reliving, in a developmentally healthy man-

ner, interactions that failed the first time around. Resistance is only important insofar as it impedes the regression that will permit growth through transmuting internalization of elements of the analyst's psychic structure. The maintenance of the nonintrusive analytic posture, thus permitting deep regression, stands in contrast with Kernberg's technique, and Kernberg strongly disagrees with this approach.

Kernberg uses different categories from those of Kohut to classify his patients. The terms neurotic and psychotic are held in common, as discussed earlier, but the term borderline is used to include all those patients who fall between those two terms. The NCDs, then, are not put in a separate category, as in Kohut's system, though their special quality of analyzability is recognized by Kernberg and Kohut. Thus, Kernberg uses the term borderline in the "loose" sense discussed earlier in this paper, and the narcissistic disturbances are included in the borderline category. Neither men consider non-NCD borderlines as analyzable, but, whereas Kohut pays little attention to this group, Kernberg focuses extensively on them. Kernberg sees unanalyzable borderlines as still being treatable, but not through psychoanalysis. They are treatable through a radically modified form of psychoanalysis called psychoanalytic psychotherapy, which can best be understood by examining Kernberg's concept of unanalyzable borderline pathology.

According to Kernberg, such pathology is based on pre-oedipal, oral conflicts due to severe, early deprivation, usually before age 2. This deprivation leads to the experience and expression of intense, impotent oral envy and rage in the form of abnormally intense, aggressive impulses, which pervade the whole affective life of such a patient. However, the patient has a defensive structure that prevents the full expression of these aggressive impulses and prevents regression to psychotically fragmented object relations. This defensive structure is based on characteristically borderline defense mechanisms, which are used to undermine and devalue strong others, such as the therapist. The patient has a propensity to idealize these others into very strong and threatening figures on whom the patient can become fatally dependent. The patient must defend against the urge to totally depend upon a stronger person, whom the patient experiences as nurturant and yet malevolent, by destroying the other person. This destructive impulse must also be defended against. The most immediate threat from the malevolent other upon whom the patient depends is abandonment. But the borderline defense system produces such chaotic relationships that often the patient is abandoning the other or undermining the relationship before enough time elapses for him to be abandoned. The specific borderline defense mechanisms are splitting, primitive idealization, primitive projection (especially projective identification), denial, and omnipotence and devaluation.

The defensive use of splitting is the hallmark of the borderline personality organization and underlies the other borderline defenses. Neurotic personali-

ties defend against conflictual thoughts and impulses through the mechanism of repression, whereby these impulses are kept unconscious. The borderline uses the mechanism of splitting for the same purpose, but rather than remaining unconscious, however, the impulses surface to consciousness, where they are dissociated through the maintenance of separate, conscious ego states. For example, a borderline patient might feel extremely angry toward a significant other, then very happy, pleased, and idealizing toward the same object, then back again to anger in a very short time. At a given moment, however, the patient does not experience these contradictory feelings as an internal conflict, or even as contradictory. He does not have the neurotic ambivalence expressed as, "I feel both love and hate for this person." He experiences "Now I hate this person" and "Now I love this person," and yet the two are put together into one conflictual experience. Splitting leads to a shifting, dichotomous perception of the world in crude, black and white terms of "all good" or "all bad."

Kernberg sees splitting in specific, developmental terms. Normally, the infant begins life without the capacity to integrate good and bad internal objects, that is, libidinally versus aggressively determined introjections and identifications. Later, these contrasting internal part objects are integrated into the core of a stable ego identity. The borderline experiences this initially normal, nonintegrative first stage and then pathologically cultivates it and uses it for later defensive purposes. The maintenance of dissociated alternating ego states is used to prevent a generalized feeling of anxiety throughout the self by protecting the libidinally derived all good ego core and by restricting anxiety to the all bad ego core, which is based on aggressively derived introjections. Therefore, the patient cannot integrate a stable identity and experiences the identity diffusion characteristic of borderlines.

Primitive idealization is a grossly unrealistic perception of the therapist as a wonderful person in all respects. The patient projects an archaic, purely good self and object representation onto the therapist and then seems to latch onto this wonderful being as an island of goodness in an all bad world. However, Kernberg states that this idealization is a defense against the patient's intensely negative and hostile transference feelings toward the therapist. Primitive idealization is used to protect the therapist from the patient's rage and to prevent the patient's projection of his own purely bad self and object representations. There are similarities here to Kohut's idealizing transference, but the two are quite different, referring as they do to different diagnostic types. For Kernberg, the therapy cannot proceed until the therapist interprets his way past the defensive use of primitive idealization as a resistance against the true, underlying negative transference.

Primitive projection is used to externalize the totally bad, aggressive self and object representations, but it creates dangerous external objects, which

the patient perceives as destructive and threatening, and from whom he must aggressively defend himself. The term projective identification refers to the patient's tendency to defend against a dangerous object, which he has created projectively, by identifying with that very same aggressive object and "empathically" becoming aggressive himself toward the object. This is expressed by the patient attacking the object before it attacks him. In this situation, the projective defense has not been very successful in externalizing the hostile impulses, which the patient still ends up experiencing directly. The primitive blurring of self and object boundaries is apparent in projective identification, whereby the patient identifies with something in another person that he projected onto that person in the first place. Kernberg emphasizes that this boundary blurring is not generalized throughout all of the borderline's experience but is focalized on aggressively charged situations.

Denial, in its crudest form, reinforces splitting. The patient seems to be unaware of the ego state that is opposite the one he is currently experiencing. When asked if he remembers a recent experience of that opposite affect, he can intellectually acknowledge the memory of the event, but he insists that that feeling is now irrelevant to him. When the ego states switch, the same thing happens in reverse. Denial can interfere in a severe but focal way with reality testing, for example, in the denial of a reality of the therapeutic relationship at the service of a transference distortion. Borderline patients also can deny the significance of external events that, realistically, are very significant to them and that, in any obvious way, they have acknowledged in the past.

A more sophisticated form of denial is the intensified expression of an affect opposite to the one being denied, for example, the manic denial of depression. Denial can be used to defend against either libidinal or aggressive impulses. Kernberg sees aggression as the main issue. The borderline patient disavows his own rage by using denial to defend against aggressive impulses. Even when the patient denies affection and other libidinal drive derivatives, he is doing so to maintain distance, prevent closeness, and thus avoid a battle of mutual destruction, which, to him, is the bottom line of any interpersonal relationship.

Omnipotence and devaluation form a pair of defenses related to splitting. In a sense, they lie behind primitive idealization, the feeling of omnipotence becoming accessible to the patient through the link with the powerful, idealized object. Because he feels omnipotent, the patient feels invulnerable and safe from the malevolent objects around him and can omnipotently control those bad objects. The desire to control is turned back on the idealized object, for example, the therapist, through attempts to manipulate and exploit him and, thus, to possess him as though he were a mere extension of the patient himself. The devaluation, aside from being an explicit put-down, is also

implicit in this manipulative, controlling action. Devaluation represents a form of control that is an attempt to defuse the malevolent power of the dangerous object.

Clearly, all these borderline defense mechanisms are intertwined with each other. Kernberg separates them not only for the purpose of clarity but also as a means to understand his approach to therapy. His analytic psychotherapy of borderline personality organizations aims first and foremost at the development of ego strength in these patients, who are characterized by general ego weakness. The ego is strengthened by bolstering its ability to test reality and by undermining those defensive operations that interfere with reality testing. All of the defenses listed earlier impair reality testing. Of course, they also maintain pathological internal object relations, but Kernberg gets at psychic structure indirectly by appealing to the rational faculties of the remaining healthy aspects of the patient's ego. The basic technique is the interpretation of defenses against the patient's aggressive impulses, especially his feelings of negative transference. This is not a regressive approach; Kernberg builds on the existing healthy structure, rather than backtracking and developing a new structure from the ground up.

Even in the case of those narcissistic personality disorders whom Kernberg feels have a cohesive enough self to tolerate the regression of psychoanalysis without fragmenting into psychosis, he does not see the grandiose self and narcissistic idealization as healthy starting points for new growth. He sees these two configurations as the outgrowth of a pathological line of development not traversed in normal development, as a detour based on the pathological fusion of archaic ego and superego (ego ideal) elements, rather than as an arrest in the normal sequence of development as described in Kohut's work. This narcissistic pathology is, in Kernberg's view, another defense against the aggressive rage characteristic of borderlines and is to be interpreted in the usual manner.

NCDs are included in Kernberg's borderline category, even those who are analyzable. But in their analyses, the pathological line of development, which has turned to defensive use against aggressive impulses, must be undone. This idea of pathological lines of development, as opposed to arrested normal development, runs throughout Kernberg's work (e.g., in the theory of the genetic basis of defensive splitting). This concept of abnormal development leads naturally to the idea of undoing pathological defenses in therapy. Kernberg sees defending against abnormally intense rage as the primary purpose of these pathological defenses. Once the self-destructive defenses are undone through interpretation, the basic issue in therapy becomes dealing realistically, rather than self-destructively, with the intense rage that underlies the patient's pathology.

Kernberg and Kohut differ in three major ways: They focus on diagnostically different patient groups, they have different etiological theories to ex-

plain the pathology with which they deal, and they use different therapeutic techniques. Within the broad category of borderline patients, there are two levels of pathology: unanalyzable borderlines, who form no stable transference, and narcissistic personality disorders, who form stable narcissistic transferences and are, therefore, analyzable. Kernberg focuses on the former, and Kohut focuses on the latter. Kernberg's concept of borderline etiology is based on the idea of abnormal lines of development of pathological defenses against abnormally intense oral rage, which is a response to extensive early deprivation. Kohut conceives of the etiology of narcissistic personality disorders in terms of an arrest in the normal development of narcissism due to lacunae in the child's experience of interpersonal interactions during the transitional period. Kernberg's psychoanalytic psychotherapy is based on the intrusive interpretation of underlying rage and the dismantling of pathological defenses to strengthen ego functioning. Kohut's psychoanalysis of narcissistic disorders is based on the regressive activation of a narcissistic transference and the unobtrusive provision by the therapist of the patient's missing psychic structure. This allows a corrective reexperiencing of a transitional period and a growth beyond it to healthy narcissism through adequate interpersonal experience with the therapist and by transmuted internalizations of elements of his psychic structure.

Kohut's writing emphasizes internal object relations and the analysis of internal psychic structure and conveys an atmosphere of serenity. Kernberg's writing emphasizes ego functions and the description of defensive dynamics and sets a tone of conflict and aggressive struggle. When it comes to his individual style as a therapist interacting with patients, Kohut is unobtrusive and nurturant in order to facilitate regression and growth, whereas Kernberg is intrusive and controlling in order to undermine pathology and bolster ego strength. A paradigmatic difference manifests itself in each writer's language. Kohut uses new language elements, which he has created. Kernberg uses a makeshift adaptation of the old psychodynamic language to broaden the application of the conflict and defense model.

Undoubtedly, these stylistic differences are related to private factors in each man's personality, but they are also related to discernible differences in the nature of each man's work. Each has made a basic choice regarding the type of patients he wants to work with. Kohut works with the analyzable narcissistic group, and Kernberg works with the unanalyzable borderline group. This choice tends to define the relation of their work to the basic Freudian paradigm. Kernberg is essentially elaborating Freud's presentation of the basic unresolved anomaly in psychoanalysis, the problem of psychosis as an untreatable form of pathology. Though Kernberg's borderlines are not psychotic, they blend into the psychotic category and share the critical quality of unanalyzability with psychotics because of their inability to form stable transferences. There is a pragmatic necessity to work out some way of dealing

with these people, but our understanding of them is not yet complete enough to constitute a solid, simple paradigm.

Work on this problem, including Kernberg's, is still at the stage of descriptive groundwork. Kohut's work with analyzable narcissistic disorders, on the other hand, presents a radically new anomaly within the Freudian paradigm. His patients fail to meet Freud's criterion of analyzability, the formation of neurotic transference, and yet they are analyzable. Kohut has discovered a whole new realm of data in the narcissistic transferences and has introduced new conceptual elements to deal with them. This has permitted him to take a step away from the Freudian paradigm and to introduce his own paradigm of the dual line of normal narcissistic development.

Atmospheres of serenity and struggle have been cited as elements of the contrast between Kohut and Kernberg. Kohut's writing conveys a serene, confident atmosphere of fulfillment and closure, a pervasive sense of the firmly intact wholeness of his conceptual system. Kernberg's writing, on the other hand, conveys an atmosphere of frustration and lack of closure, a feeling of aggressive struggle and wrestling with conflicts. This difference in tone is related to the difference in the paradigmatic status of each man's work, which, in turn, is related to the differences in the diagnostic features of the patient groups with which each man deals. Kohut achieves the confident insight of a coherent paradigm by restricting the realm of his work to the narrowly bounded area of narcissistic disturbances. Kernberg broadens the scope of his work to include a wider range of uncharted clinical experience; however, he pays the price in closure and integrated wholeness.

Each approach has its advantages and liabilities. This relates to the early discussion of resistance to self-understanding in the study of the self. Kohut overcomes this resistance by constricting the boundaries of the realm of his study, and thus he achieves deep insight into a narrow realm of experience. The drawing of such a boundary is a critical first step, which depends upon the differentiated perception of a distinct, separate entity. Kernberg does not achieve such deep understanding, but he takes a wider sweep. Presumably, the task of the future is to integrate depth and breadth in one paradigm. Kohut's work holds a special place in this unfolding self-understanding because it focuses an intense beam on the self per se, on a further understanding of our being as selves, and on the development of our experience of selfhood. This extension of self-consciousness leads to an extension of the self that possesses it because one of the primary components of selfhood is coherence. In rendering our self-understanding more coherent, the coherence of the self is enhanced.

Kohut's study of the grandiose self and the idealized parent imago represents an important contribution to the phenomenology of the self that is developing out of the psychoanalytic tradition. Because Kernberg deals with a wider range of pathology, he must rely on the old Freudian paradigm of in-

ternal conflict and defense, which, despite its pragmatic value, fails to produce a true phenomenology of borderline experience. Kernberg does, however, describe many aspects of borderline experience that might be incorporated into this type of coherent phenomenology. Kohut and Kernberg are pioneers in an unfolding exploration of disturbances of the self. The future will tell where further understanding of the self will lead.

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