Instructor’s Manual for

OTTO KERNBERG:
LIVE CASE CONSULTATION

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Tips for Making the Best Use of the DVD

1. USE THE TRANSCRIPTS
Make notes in the video Transcript for future reference; the next time you show the video you will have them available. Highlight or notate key moments in the video to better facilitate discussion during and after the video.

2. FACILITATE DISCUSSION
Pause the video at different points to elicit viewers’ observations and reactions to the concepts presented. The Discussion Questions section provides ideas about key points that can stimulate rich discussions and learning.

3. ENCOURAGE SHARING OF OPINIONS
Encourage viewers to voice their opinions; no therapy is perfect! What are viewers’ impressions of what works and does not work? We learn as much from our mistakes as our successes; it is crucial for students and therapists to develop the ability to effectively critique this work as well as their own.

4. SUGGEST READINGS TO ENRICH VIDEO MATERIAL
Assign readings from Related Websites, Videos and Further Reading prior to or after viewing.

5. ASSIGN A REACTION PAPER
See suggestions in the Reaction Paper section
Transference Focused Psychotherapy (TFP)
Otto F. Kernberg, M.D.

1. Strategies

The main strategy in the transference focused psychotherapy (TFP) of borderline personality organization consists in the facilitation of the (re)activation in the treatment of split-off internalized object relations of contrasting persecutory and idealized natures that are then observed and interpreted in the transference.

TFP is carried out in face-to-face sessions, a minimum of two and usually not more than three sessions a week. The patient is instructed to carry out free association (in a detailed, precise way), and the therapist restricts his or her role to careful observation of the activation of regressive, split-off relations in the transference, and to help identify them and interpret their segregation in the light of these patients’ enormous difficulty in reflecting on their own behavior and on the interactions they get involved in. The interpretation of these split-off object relations is based upon the assumption that each of them reflects a dyadic unit of a self-representation, an object-representation and a dominant affect linking them, and that the activation of these dyadic relationships determines the patient’s perception of the therapist and occurs with rapid role reversals in the transference, so that the patient may identify with a primitive self-representation while projecting a corresponding object representation onto the therapist, while, ten minutes later, for example, the patient identifies with the object representation while projecting the self-representation onto the therapist. Engaging the patient’s observing ego in this phenomenon paves the way for interpreting the conflicts that keep these dyads, and corresponding views of self and other, separate and exaggerated. Until these representations are integrated into more nuanced and modulated ones, patients will continue to perceive themselves and others in exaggerated, distorted and rapidly shifting terms.

The overall strategy mentioned, namely the resolution of identity
diffusion and the integration of mutually split-off idealized and persecutory relationships, is facilitated by the fact that unconscious conflicts are activated in the transference mostly in the patient’s behavior rather than in the emergence of preconscious subjective experiences reflecting unconscious fantasy. The intolerance of overwhelming emotional experiences is expressed in the tendency to replace such emotional experiences by acting out, in the case of most borderline patients, and somatization, in some other personality disorders. The fact that primitive conflicts manifest themselves in dissociated behavior rather than in the content of free association is a fundamental feature of these cases that facilitates transference analysis with a relatively low frequency of sessions, while the very intensity of those conflicts facilitates the full analysis of these transference developments.

2. Tactics

The tactics are rules of engagement that allow for the application of psychoanalytic technique in a modified way that corresponds to the nature of the transference developments in these cases. The tactics are: 1) setting the treatment contract, 2) choosing the priority theme to address in the material the patient is presenting, 3) maintaining an appropriate balance between, on the one hand, exploring the incompatible views of reality between the patient and therapist in preparation for interpretation and, on the other, establishing common elements of shared reality, and 4) regulating the intensity of affective involvement.

In the establishment of an initial treatment contract, in addition to the usual arrangements for psychoanalytic treatment, urgent difficulties in the borderline patient’s life that may threaten the patient’s physical integrity or survival, or other people’s physical integrity or survival, or the very continuation of the treatment, are taken up. Conditions are set up under which the treatment can be carried out that involve certain responsibilities for the patient and certain responsibilities for the therapist.

With regard to choosing which theme to address at any given moment in the material the patient brings to the session, the most important
tactic is the general analytic rule that interpretation has to be carried out where the affect is most intense: affect dominance determines the focus of the interpretation. The most intense affect may be expressed in the patient’s subjective experience, in the patient’s nonverbal behavior, or, at times, in the countertransference--in the face of what on the surface seems a completely frozen or affectless situation. The simultaneous attention, by the therapist, to the patient’s verbal communication, non-verbal behavior, and the countertransference permits diagnosing what the dominant affect is at the moment--and the corresponding object relation activated in the treatment situation. Every affect is considered to be the manifestation of an underlying object relation.

The second most important consideration in determining the selection of what is interpreted is the nature of the transference. When major affect development coincides with transference development that becomes easy to determine, but there are times where most affect occurs related to extra transferential conditions or the patient’s external world.

Still another tactical approach relates to certain general priorities that need to be taken up immediately, whether they reflect affective dominance or not in the session, although they usually do so anyway. These priorities include, by order of importance: 1) suicidal or homicidal behavior, 2) threats to the disruption of the treatment, 3) severe acting out in the session or outside, that threaten the patient’s life or the treatment, 4) dishonesty, 5) trivialization of the content of the hour and 6) pervasive narcissistic resistances, that must be resolved by consistent analysis of the transference implications of the pathological grandiose self. When none of these priorities seems dominant at the moment in the hour, the general tactic of affective dominance and transference analysis prevails.

An important tactical aspect of a treatment involves conditions of severe regression, including affects storms, micropsychotic episodes, negative therapeutic reactions, and “incompatible realities.” We have developed specific technical approaches to these situations; the description of all of them would exceed the limits of this summary.
3. Techniques

While “strategies” refer to overall, long range goals and their implementation in transference analysis, and “tactics” to particular interventions in concrete hours of treatment, “techniques” refers to the general, consistent application of technical instruments derived from psychoanalytic technique. The main technical instruments of Transference Focused Psychotherapy (TFP) are the essential techniques of psychoanalysis, namely, interpretation, transference analysis, and technical neutrality.

Transference analysis differs from the analysis of the transference in standard psychoanalysis in that it is always closely linked with the analysis of the patient’s problems in external reality, in order to avoid the dissociation of the psychotherapy sessions from the patient’s external life. Transference analysis also includes an implied concern for the long range treatment goals that, characteristically, are not focused upon in standard psychoanalysis, except if they emerge in the transference. Deviation from technical neutrality may be indispensable in order to protect the boundaries of the treatment situation, protect the patient from severe suicidal and other self-destructive behavior, and requires a particular approach in order to restore technical neutrality once it has been abandoned. Technical neutrality, in short, fluctuates throughout the treatment, but is constantly worked on and reinstated as a major process goal.

The intensity of the countertransferences evoked by patients with severe character pathology and consequent severely regressive behavior and acting out in the transference requires an ongoing alertness to countertransference developments that the therapist has to tolerate in himself/herself, even under conditions of significant regression in countertransference fantasies and impulses of an aggressive, dependent, or sexual kind. That internal tolerance of countertransference permits its analysis in terms of the nature of the self representation or the object representation that is being projected onto the therapist at that point, facilitating full interpretation of the dyadic relationship in the transference, so that countertransference is utilized in the therapist’s mind for transference clarification.
Reaction Paper for Classes and Training

Video: Otto Kernberg: Live Case Consultation

- **Assignment:** Complete this reaction paper and return it by the date noted by the facilitator.
- **Suggestions for Viewers:** Take notes on these questions while viewing the video and complete the reaction paper afterwards. Respond to each question below.
- **Length and Style:** 2-4 pages double-spaced. Be brief and concise. Do NOT provide a full synopsis of the video. This is meant to be a brief reaction paper that you write soon after watching the video—we want your ideas and reactions.

**What to Write:** Respond to the following questions in your reaction paper:

1. **Key points:** What important points did you learn about Otto Kernberg’s approach to psychotherapy? What stands out to you about how Kernberg works?

2. **What I found most helpful:** As a therapist, what was most beneficial to you about the ideas presented? What tools or perspectives did you find helpful and might you use in your own work? What challenged you to think about something in a new way?

3. **What does not make sense:** What principles/techniques/interventions did not make sense to you? Did anything push your buttons or bring about a sense of resistance in you, or just not fit with your own style of working?

4. **What I see differently:** What are some of your views that are different from what Kernberg describes in this video? Be specific about what points you disagree with him on.

5. **Other questions/reactions:** What questions or reactions did you have as you viewed the video? Other comments, thoughts or feelings?
Related Websites, Videos and Further Reading

**WEB RESOURCES**

Dr. Kernberg’s homepage at Weill Cornell Medical College

www.weillcornell.org/ottokernberg/index.html

Website for the Personality Disorders Institute of the Weill Medical College of Cornell University

www.borderlinedisorders.com/personality-disorders-institute-professionals.php

Psychotherapy.net interview with Dr. Kernberg

www.psychotherapy.net/interview/otto-kernberg

Borderline Personality Disorder Demystified: Website of Robert Friedel, MD

www.bpddemystified.com

**RELATED VIDEOS AVAILABLE AT**

WWW.PSYCHOTHERAPY.NET

Psychoanalytic Psychotherapy for Personality Disorders: An Interview with Otto Kernberg, MD

Irvin Yalom: Live Case Consultation

James Bugental: Live Case Consultation

Arnold Lazarus: Live Case Consultation

Object Relations Therapy with Jill Savege Scharff

Object Relations Child Therapy with David Scharff

**RECOMMENDED READINGS**


Discussion Questions

Professors, training directors and facilitators may use some or all of these discussion questions, depending on what aspects of the video are most relevant to the audience.

1. **Overall Impressions**: What were your overall impressions of these consultation sessions? Do you think that Kernberg was helpful to each of the therapists? Did you like his style of asking questions and gathering information, as well as giving input? What about his style or contributions stood out to you as particularly helpful or unhelpful? Why?

2. **Love**: What did you think about Kernberg inquiring into each patient’s capacity to love? Why do you think this was so important to him? Do you generally get a sense of your patients’ capacity to love? What other areas of their functioning do you think it is crucial to get a full picture of?

CASE ONE: CONFRONT THE CLIENT’S REALITY

3. **Diagnosis**: As you listened to Amy describe her client, what kinds of diagnoses did you consider? What do you think of Kernberg’s evaluation that Amy’s client does not have PTSD, as Amy had thought, but that she has a severe personality disorder? Do you agree with him? Why or why not?

4. **Focus on Sexuality**: Although Amy did not raise the sexual relationship between the client and her husband as a primary concern for the consultation, Kernberg focused quite a bit on this. How did you react to Kernberg’s statements such as “her [the client’s] not wanting to have a normal sexual life like an adult woman would is a problem,” as well as his encouragement to Amy to address this issue more directly in the therapy? What do you think of Kernberg’s interpretation that the client’s not being interested in sex “protects her from envy and competition and permits her to stay in a position in which she’s a victim”? Was this an interpretation you had considered as you listened to Amy discuss her client? If not, did you come up with any other interpretations?
CASE TWO: DON’T IGNORE THE PRESENT

5. “Psychoanalytic Disease”: In response to Steve’s case, Kernberg spoke about the “psychoanalytic disease” of focusing on the past more than the present. What was your reaction to this? Do you associate psychoanalysis with a focus primarily on the past? Did Kernberg’s point about the importance of asking his client more about his present life make sense to you? Why or why not?

6. Evaluation: Kernberg stressed the importance of engaging the patient in a psychiatric evaluation, before encouraging the patient to engage in free association. Do you lead your patients through a thorough mental status examination using questions that Kernberg recommended, or do you take a different approach to finding out about your patients? Why or why not? What about Kernberg’s method of evaluation do you like and dislike? Is there anything he recommended in terms of evaluation that you might consider implementing into your approach? If so, what?

7. Manipulation: What was your reaction when Kernberg stated that Tom managed to manipulate and seduce Steve? Based on the information Steve shared, did you agree with Kernberg? Why or why not? Did this type of seduction and/or manipulation remind you of any patients you have worked with?

8. Style: How did you react when Kernberg said to Steve, “I would say there’s something problematic about your style”? Did you agree with Kernberg? Have you ever had a supervisor or consultant say something like that to you? If so, how was that for you? Did you find it helpful? Why or why not?

CASE THREE: SEXUAL INHIBITION AND PARAPHILIA

9. David: What were your reactions to Annie’s presentation of her client, David? Did you agree with Kernberg that it sounds like David has a severe personality disorder? Why or why not? Did you find yourself agreeing with Kernberg’s interpretations of what is going on for David, such as that he is dismissing Annie’s efforts to help him? What other thoughts did you have about what might be going on for David?
10. **Encouraging Sexual Exploration:** Were you surprised that Kernberg supported Annie’s overall approach in encouraging her client to explore his sexual fantasies, including engaging in behaviors that seemed masochistic? Why or why not? Did his comments seem consistent with “therapeutic neutrality” that is often seen as a cornerstone of psychoanalytic approaches?

**GENERAL REACTIONS**

11. **Approach:** Based on these consultations, how would you describe Kernberg’s approach to psychotherapy? How is his style and approach similar to and different from yours? What aspects of his approach and/or style might you incorporate into your work?

12. **Personal Reaction:** How would you feel about having Kernberg as your consultant or supervisor? How about as your therapist? Do you think he could build a solid alliance with you? Would he be effective with you? Why or why not?
INTRODUCTION

Hello, I’m Victor Yalom. In a few minutes, we’re going to take a rare glimpse into the consulting room with our guest, Dr. Otto Kernberg. Dr. Kernberg is really a man who needs no introduction. He’s been a distinguished contributor in the fields of psychoanalysis, psychoanalytic psychotherapy, and psychotherapy research, with a particular focus on working with personality disorders. Welcome, Dr. Kernberg.

Dr. Kernberg: Thank you.

Victor: Just to get started before we watch these case consultations, can you say a few words about how you approach case consultation, and of course, how it differs from psychotherapy?

Dr. Kernberg: Well, it depends on what the consultation is all about.

Victor: Of course.

Dr. Kernberg: I first try to listen attentively to the therapist. What’s the problem that he wants to talk about? What’s the difficulty he has? How, or in what way, does he hope I will be able to help him? And I orient the consultation to that question. And that varies from case to case. That’s one principle.

A second, more general principle is that I try to assess what seems to me the dominant difficulty in the treatment at this time. And for that, what I need is a kind of a brief orientation about the present situation of the treatment, meaning get some idea about the patient. What are the principal reasons for which he came? And what’s roughly his present situation in three major areas of life: love and sex, work and profession, social life and creativity?

I try to find out a little about that, sufficient so I can see what is the major problem in any of these areas and in the treatment. And then I ask the therapist: What is the diagnosis? What’s going on in the treatment right now? What’s the difficulty? And usually
the combination of the diagnostic assessment—what’s the present difficulty—and what I have already learned about why the patient came, and what’s going on in his life situation gives me a sense where the greatest problem is.

It may well be that it’s in the transference, in some life situation that is expressing his dominant conflicts that has to be looked at from that viewpoint in some particular difficulty that the therapist has. And I’m very attentive to the therapist’s response to me when I raise questions about that difficulty, because very often in that interaction, I can see what the issues are: why the therapy, or the therapist, is stuck at a certain point.

**Victor:** So you’re looking for some parallel process in the consultation and the therapy?

**Dr. Kernberg:** Yes, I’m looking for some parallel process. Some parallel process, and I’m also looking, sometimes, even for some areas in which the therapist doesn’t have the knowledge, or expertise, or doesn’t use it as he should, or is stuck in a countertransference position.

**Victor:** Right. So those are important distinctions: whether it’s a countertransference problem, whether there’s some parallel process, or whether they simply need to develop some skills further.

**Dr. Kernberg:** Yeah, right. So I try to be as open and flexible, and let myself be guided by what emerges.

**Victor:** And just like in your work, from what I understand, your focus in the consultation is more on what the present problem is in the treatment versus formulating some complete, comprehensive diagnostic workup of the patient.

**Dr. Kernberg:** Yeah. If the therapist starts telling me about the background of the patient, I rapidly and tactfully tell him, “Let’s go back. What’s the present problem?”

**Victor:** Yes. And we’ll see that you do that in some of these consultations.

**Dr. Kernberg:** I hope so.
Victor: Good. So let’s take a look at them now, and then you and I will meet at the end and have a few more words.

Dr. Kernberg: Yeah. Very good.

CASE 1: CONFRONT THE CLIENT’S REALITY

Dr. Kernberg: Welcome to this case consultation. I understand that Amy is going to present a case first, and I’ll try to be helpful with it if I can. Go ahead.

Amy: Okay, so I wanted to talk about one of my clients. She is a 45-year-old Caucasian female. She has three children. She’s married. She’s a stay-at-home mom. And she has an extensive history of sexual abuse within her family. She was pregnant at age 17 by her father, and she had an abortion.

Dr. Kernberg: By whom?

Amy: By her father, and she had an abortion at that time, but none of the family is aware of that. There was also sexual activity between the siblings; between brothers and sisters and mom and dad with the children as well as the extended family with the uncles. They would play...

Dr. Kernberg: Let me interrupt you. Did you say between mom and dad and the children?

Amy: Between mom and the children and dad and the children.

Dr. Kernberg: Okay.

Amy: Okay?

Dr. Kernberg: Everybody had sex with everybody in that family?

Amy: Yes, yes.

Dr. Kernberg: Okay, all throughout the patient’s childhood?

Amy: Yes.

Dr. Kernberg: Through the adolescence, through her getting pregnant with her father?

Amy: Yes, yes.

Dr. Kernberg: Okay.
Amy: And they would play with the uncles as well. They would play poker in the basement, and whoever won then would receive sex with her. And then, whoever the winner was, whichever uncle it was would go upstairs. So it’s an extensive sexual abuse history.

She left the home at college, and at that point, was no longer involved with her father after she got married. She got married and she decided to leave that environment.

For the past, I would say it’s not so much in the past couple of years, but she did have a relationship with a female. She was involved in an extramarital affair with a female, and in the past couple of years, has not been involved sexually with that person.

I’ve been seeing her for about five years. And I guess one of my questions or the place where I’m feeling stuck is that she seems to— She sees things very black and white. Like, she’ll have an emotion and she’ll say that’s not an okay emotion, and religion plays into it as well. Like, what her parents told her was that they were teaching her how to be a good wife. That’s why they taught her sexual acts: to teach her to be a good wife, and also that’s what love was. So she has a lot of confusion about what love is and what’s right and wrong in her mind. So she’s really, really critical of herself.

Where I’m feeling stuck is that she continues to find herself in the victim role with her own husband. There’s a lot of similarities in that relationship as there were with her own family. So she feels like he uses sex. She feels like he has a sexual addiction. So she will use sex to calm him down. If he gets angry, then she’ll have sex with him, and she feels like that calms him down. She’s afraid not to do that because she’s afraid that he…

Dr. Kernberg: I didn’t quite understand that.

Amy: Okay.

Dr. Kernberg: She uses sex as a kind of challenge or blackmail? I didn’t understand that.

Amy: If she starts being anxious that he’s getting angry, she feels like she has to then have sex with him to calm him down so that he doesn’t yell at the children, or yell at her, or just doesn’t get angry. So she uses
it, what she says, to calm him down. So it feels like it gives her some power, but it’s also because she doesn’t want him to be angry.

So it’s been difficult…

**Dr. Kernberg:** Does she enjoy sex or not?

**Amy:** No, she reports that she does not enjoy it.

**Dr. Kernberg:** Is she orgasmic? Has she ever had an orgasm, or how severely inhibited is she sexually?

**Amy:** She says that she will pretend that she is enjoying it but that she’s not enjoying it.

**Dr. Kernberg:** Does she have any sexual excitement at all? Does she get aroused or not? Does she get excited during intercourse? Does she achieve orgasm sometimes, never?

**Amy:** She’s reported that she doesn’t enjoy it at all. She says she hates it.

**Dr. Kernberg:** She has never enjoyed it?

**Amy:** That’s what she’s reporting. I don’t know if that’s 100-percent accurate, but that’s what she reports to me.

**Dr. Kernberg:** Why wouldn’t it be accurate? Is she dishonest? Is she lying?

**Amy:** No, not in general. She’s pretty honest, I think.

**Dr. Kernberg:** Not in general?

**Amy:** No.

**Dr. Kernberg:** You mean sometimes she does?

**Amy:** No, she doesn’t.

**Dr. Kernberg:** So she’s always straight with you?

**Amy:** Yes.

**Dr. Kernberg:** So why would you doubt her telling you that she has never had sexual excitement or orgasm?

**Amy:** I think that for her to say that she had would be scary for her to say that she does. I think it would be scary for her to say she enjoys any
part of it.

**Dr. Kernberg:** Why? Why would it be scary?

**Amy:** Because then, she considers herself bad, because she enjoys it.

**Dr. Kernberg:** Okay.

**Amy:** She also, by the way, a few years ago—If her husband was yelling at the children, she felt bad for the children, and so she would lay in bed with them and fondle them. That’s no longer occurring either. But that’s kind of the same way she was brought up, was a lot of poor boundaries around sex.

**Dr. Kernberg:** When you are saying this is the way she was brought up, is that what she says to you, that “this is the way I was brought up,” or you are putting it in? Do you follow me?

**Amy:** Yeah, well, I’m just saying that sex was how you show love to each other in her family of origin. And so she was starting to play out some of those things in her own family with her own children.

**Dr. Kernberg:** I mean, is she aware of that? Is she saying that, or that’s your interpretation of her behavior?

**Amy:** We’ve talked about that. We’ve talked about that, and it’s been a big struggle for her because then she says to me, “Well, then how do I show love to my kids?”

**Dr. Kernberg:** Okay. So it’s her conviction. It comes directly from family.

**Amy:** Yes, she’s very confused about what love is.

**Dr. Kernberg:** Yeah, did she have any sexual pleasure in the relation with the woman with whom she had an affair?

**Amy:** No, she reports that she did not. She reports that what she was really looking for was nurturance and comfort from that woman, and that woman then would ask for sex. And she would do that, because she didn’t want her to get mad.

**Dr. Kernberg:** Was she in love with that woman?

**Amy:** She wanted the nurturance, the physical nurturance, and the comfort.
Dr. Kernberg: Is she in love with her husband?

Amy: No.

Dr. Kernberg: Was she ever in love with her husband?

Amy: No, she reports she was not. She says she only got married to get out of her family of origin.

Dr. Kernberg: Has she ever been in love with anybody, or not really?

Amy: Not that she’s reported. I mean, she loves her children.

Dr. Kernberg: She loves the children.

Amy: Yes.

Dr. Kernberg: So that’s authentic. So she knows what it is to love somebody.

Amy: Yes.

Dr. Kernberg: She has good relation with her children.

Amy: Yes.

Dr. Kernberg: Okay. And what’s the reason for which she comes to treatment? What does she expect from treatment?

Amy: She came initially—She also has chronic pain issues. So she came initially at the referral of her doctor due to chronic pain issues, and they thought maybe some of it was psychological issues as well.

Dr. Kernberg: What kind of pain?

Amy: She was in a car accident just prior to coming to treatment and it caused—She had to have neck surgery, and it caused pain down her back and her arm.

Dr. Kernberg: Is there still some litigation going on around the accident?

Amy: No, but the insurance company does cover some of her treatment.

Dr. Kernberg: And that is now stable in the sense that coverage is not threatened if her pain goes away?

Amy: I’m not sure.
**Dr. Kernberg:** Okay, do you know why I’m asking that?

**Amy:** Yeah, that’s very important.

**Dr. Kernberg:** They have the problem of secondary gain, and whenever there is so-called “compensation neurosis,” problem of secondary gain becomes very important, and secondary gain of illness is one of the prognostically negative factors in addition to antisocial behavior, the two most important prognostically negative factors. And with a patient who has been exposed to such a perverse family situation, the question arises to what extent there is severe pathology of superego functioning.

Is there any history of antisocial behavior? Passive parasitic type or aggressive type? Lying, dishonesty, irresponsibility with money, stealing, cheating, conning, or being aggressive, destruction of object, attack on people, anything like that? Problems with the law?

**Amy:** No, she hasn’t had those aside from just difficulties in relationships with people.

**Dr. Kernberg:** What difficulties?

**Amy:** Feeling like… She very much wants—if she has a friend, she wants that friend solely to be friends with her, and she’s really threatened if that person has friends with anyone else. And… Some passive-aggressive tendencies.

**Dr. Kernberg:** How does it show?

**Amy:** How does it show? It seems like it shows up with some of her pain. It’s like that’s how she kind of gets attention. If she has more pain, maybe she’ll get more attention. She does go to a pain clinic and she’s on several medications. So I don’t really see her necessarily getting attention through that aspect, but wanting attention from her family due to her pain.

And being told she can’t do things, but she’ll do them anyways. So her husband will be like, “No, don’t do that.” But she’ll do it anyways, or even in session, she gets very aggravated if she feels like somebody else is getting attention for something that isn’t as severe as her own pain. Like, if somebody got hurt, but it’s not like an intense injury and they get attention, like her husband possibly, she’s very frustrated that then
she doesn’t get more attention, because her pain is worse.

**Dr. Kernberg:** So she came to treatment to be helped with her pain?

**Amy:** Yes, initially, but, to be helped with her pain, but also suicidal ideation and awareness that she grew up in a household with a lot of unhealthy patterns.

**Dr. Kernberg:** Suicidal why? Because she’s depressed, or as a way of getting attention, or expression of rage, or what?

**Amy:** I believe from depression.

**Dr. Kernberg:** So she was also depressed?

**Amy:** Yes.

**Dr. Kernberg:** About what?

**Amy:** Feeling like she couldn’t control a lot of things in her life.

**Dr. Kernberg:** Like what?

**Amy:** Her husband. This relationship with the woman—she had a lot of guilt about that. Her children—she has two children who have been diagnosed with Asperger’s.

**Dr. Kernberg:** How many children does she have, three?

**Amy:** She has three boys.

**Dr. Kernberg:** And two of them have Asberger’s?

**Amy:** Yes.

**Dr. Kernberg:** So that’s a major weight on her.

**Amy:** Yes.

**Dr. Kernberg:** Is she dedicated? What does she do—Is she mostly dedicated to the children? How old are the children?

**Amy:** Yes, 10, 13, and 16.

**Dr. Kernberg:** Does she work or do anything?

**Amy:** She is at home full-time.

**Dr. Kernberg:** And what does her husband do?

**Amy:** He is a computer engineer.
Dr. Kernberg: Okay.

Amy: And he works a lot, really long hours. She’s wondered before if he’s not having an affair. In fact, she’s told him to have an affair, because she thought if she told him to have an affair then he wouldn’t want sex from her.

Dr. Kernberg: She wouldn’t care about his having an affair. She would be relieved?

Amy: She says that she told him she wanted him to have an affair, but she doesn’t know for sure if he is, but she suspects it.

Dr. Kernberg: Okay. Does she see that as a problem or not really?

Amy: Yes, she feels like he is a sex addict and she sees that as a problem, and she’s invited him into treatment, but he refuses to come.

Dr. Kernberg: And what makes her think that he’s a sex addict?

Amy: She thinks he’s a sex addict because he comes home with some sex toys. He’ll go on a business trip, and he’ll come home with sex toys. And he’ll handcuff himself and then throw the key away so that it places the situation more in her hands. Otherwise, he would just lay there.

Dr. Kernberg: So he wants her to be involved in sadomasochistic play?

Amy: Yes.

Dr. Kernberg: And that’s why she calls him a sex addict?

Amy: Yes.

Dr. Kernberg: How often does he want to have sex?

Amy: I believe he would probably every day.

Dr. Kernberg: Okay.

Amy: From what she reports.

Dr. Kernberg: Does she have any other problem other than what you’ve told me so far?

Amy: I think that’s all I can think of right now.

Dr. Kernberg: And she comes to treatment because of her pain, most
of that, and because…

**Amy:** At this point, it’s more because of the effects of the abuse and the conflict with her husband.

**Dr. Kernberg:** The conflict—His demanding sex and she not wanting it?

**Amy:** Yes, and she feels like he has an anger problem, and that scares her, and how does she deal with that?

**Dr. Kernberg:** Okay. No other problems?

**Amy:** Well, problems with relationships. She’s aware of that as well. She has a hard time getting close to other…

**Dr. Kernberg:** The feeling of resentment if other people get more attention?

**Amy:** Yes.

**Dr. Kernberg:** Okay. And what has been your diagnosis?

**Amy:** I think the initial diagnosis was post-traumatic stress disorder, but she also has symptoms of borderline personality disorder. She sees things in black and white all the time, including myself and including any issues that we’re talking about. We might be talking about an issue and making some progress, and then she’ll be like, “Well, this isn’t right. I shouldn’t be thinking this. This is a bad thought.” Those kind of things.

**Dr. Kernberg:** I didn’t quite understand that.

**Amy:** Oh, okay. She’s very black and white in her thinking about what we’re talking about as well. We may be making some progress on an issue, and then she’ll stop herself and she’ll say, “Well, that’s a bad thought for me to have. I shouldn’t be having that thought. My parents really did love me. They really were trying to teach me. Isn’t that what parents really do?” So she really reverts back and forth.

**Dr. Kernberg:** Yeah. So all of this makes you think that she has a personality disorder as well?

**Amy:** Yes.

**Dr. Kernberg:** Of what kind?
Amy: I think there’s borderline traits there.

Dr. Kernberg: Yeah, that’s how she sounds, and perhaps also narcissistic traits—her incapacity to love, her never having been in love, the indifference toward the husband, the total absence of jealousy inviting him to have sex. And, of course, a severe sexual inhibition—a very severe sexual inhibition, right?

Amy: Yes.

Dr. Kernberg: Okay, and do you have her in psychotherapy? How often do you see her?

Amy: I see her every week, once a week.

Dr. Kernberg: You see her once a week?

Amy: Yes.

Dr. Kernberg: And what kind of psychotherapy are you doing?

Amy: Mostly like client-centered. We’re just kind of—She takes the lead, and then we talk about whatever is going on for her. And a lot of what we’re doing right now is focusing on where are some of those behaviors and choices coming from? And then, how is she getting triggered from her past? Because she’s really just repeating a lot of the things she experienced.

Dr. Kernberg: Yeah. And what are your goals for treatment?

Amy: I think to improve her relationships and her ability to be close to people. I think that’s the main issue. And also to reduce her being triggered and to increase her sense of control in her own life. She feels like she’s just at the mercy of her husband.

Dr. Kernberg: That she doesn’t—I missed that. That she doesn’t…

Amy: She thinks she’s just at the mercy of everyone, especially her husband. And so, to try to increase her sense of control in her life and setting boundaries with people and feeling like she has choices in situations.

Dr. Kernberg: In what ways is she at the mercy of her husband? Because he has these sexual wishes and she has to fulfill them?

Amy: Yes, yes. Or she’ll go to the bathroom, and he’ll come in the
bathroom naked and want her to perform oral sex. So she can’t even like—She feels like she can’t even go in there and have her own privacy to use the bathroom when he comes in, and she feels very intruded upon by him.

**Dr. Kernberg:** Yeah, right. Has she talked with him about that, that she resents that?

**Amy:** Yes.

**Dr. Kernberg:** And how does he react to that?

**Amy:** He says he doesn’t want to hurt her, but he continues to do those things, and he continues to ask for those things. She’ll go upstairs, and he’ll say, “I’m going to bed.” And she’ll go upstairs, and he’ll be handcuffed again. And she will have asked him not to do that.

**Dr. Kernberg:** Yeah, okay. How long have you seen them?

**Amy:** For about five years.

**Dr. Kernberg:** You’ve seen her for five years?

**Amy:** Yes.

**Dr. Kernberg:** Has she improved?

**Amy:** Yes, she has.

**Dr. Kernberg:** In what way?

**Amy:** She, initially, would not even be able to talk about a lot of that, and a lot of shame, and a lot of even more severe black-and-white thinking as far as her behaviors or her feelings. And I think she has increased her awareness of how her past impacts her today and become aware of situations where she may have some choices where, before, she didn’t think she did.

**Dr. Kernberg:** So things are going well?

**Amy:** Things are going fairly well. It feels like sometimes we get stuck, though, because she continues to resort back to the black and white thinking. We’ll make some progress, because she’ll be thinking, “Oh, okay, well, I do have some control.” And then, the next thing she’s like, “Well, I don’t deserve to have control. I shouldn’t have control. This person is too scary. Really, I don’t have control. And I’m bad for even
thinking that I could have a choice in this situation. So really, I’m just a victim again.” She doesn’t say that, but she continues to resort back to being in the victim role.

**Dr. Kernberg:** Yeah, but you feel you’ve been helping her to reduce that role as a victim?

**Amy:** Yes.

**Dr. Kernberg:** So what’s the reason for the consultation? What do you expect from me?

**Amy:** I guess I would like some help with her continuing to feel like she’s in that victim role, and some insight into helping more with her black-and-white thinking.

**Dr. Kernberg:** Okay. Well, I have a number of difficulties with the case. In general, you have been helping her. She’s getting better, and so your treatment is effective. I take it, it is a form of what I would call a supportive psychotherapy, with the concentration on cognitive behavioral issues, rather than psychodynamically oriented. Is that a fair statement?

**Amy:** I think it’s a mixture. I have also done some EMDR with her, and I felt like that was very useful, but she was uncomfortable with it.

**Dr. Kernberg:** She was uncomfortable with what?

**Amy:** EMDR. She was uncomfortable with getting that close to some of the issues, underlying issues. I thought that she was making some really good gains.

**Dr. Kernberg:** Yeah, but what are the underlying issues that she felt uncomfortable with and that she has difficulty facing?

**Amy:** Feeling like she’s not lovable. That’s a huge one.

**Dr. Kernberg:** Okay. Well, first of all, I have a problem with the diagnosis.

**Amy:** Okay.

**Dr. Kernberg:** I don’t think she has PTSD. Of course, she has been severely traumatized, has been growing up in a totally perverse environment. I mean, that must have caused severe distortions in her
personality and particularly in her internalized ethical value systems, what I would call her “superego functioning.” And of course, one way in which she has protected herself against that terrible environment is by total inhibition of all her sexual life. So sex is something she does to calm her husband, to soothe him, but not because it’s an enjoyable function. So she’s missing out on a major function of life because it’s connected with a breakdown of all ethical principles and directly connected with that terrible childhood.

Well, it seems to me, one has to differentiate between PTSD syndrome, that has specific symptoms, and that usually happens between six months and two or three years after a major trauma, and severe sexual abuse as an etiological factor of a severe personality disorder, and I think that that’s what she presents. And I agree with you that there are borderline features, the division of people, absolutely good and bad, and alternation between black and white emotional states that don’t touch each other.

And in addition to the infantile childlike way of judging what the marital relation is all about. It is as if she had no idea that you get married and the main function of marriage is to have a happy relationship with somebody else. And if you don’t have it, you either try to work on it and resolve that or raise question to what extent you want to spend your life with that. Of course, she has a very difficult situation with the children, so there are objective problems. And she’s able to love the children, so she doesn’t have an, certainly not an antisocial personality and doesn’t have antisocial, significant antisocial features which one could expect from such a perverse childhood. So that’s a good element.

On the other—If this seems reasonable, that pain is really a psychosomatic expression of psychological conflict and not simply a direct consequence of the accident, we, secondary gain, potentially a secondary gain of it. That means that that pain may be difficult to resolve.

My recommendation would be to try to assure herself that whatever compensation she gets is either terminated or firm, so that she doesn’t need to hold onto the symptom to feel safe financially. If you can
somehow control or eliminate secondary gain, the prognosis for the treatment of that will improve.

And her main conflict right now is with her husband. Have you seen the husband?

Amy: No, he won’t come in.

Dr. Kernberg: Have you asked him to come in? How do you know that he won’t?

Amy: Yes, I did ask him.

Dr. Kernberg: And he refused?

Amy: He said he would think about it, but then he never came in.

Dr. Kernberg: But did you ask him because you wanted him in the treatment of her?

Amy: Yes.

Dr. Kernberg: And so, he understood it was not because he was going to be forced into treatment, but so he was going to be, so to speak, a consultant to you?

Amy: Yes.

Dr. Kernberg: And he refused to do that?

Amy: Yes.

Dr. Kernberg: Why? With what reason?

Amy: He didn’t give a reason.

Dr. Kernberg: That is strange. Has she talked with him about that?

Amy: Yes, on many occasions.

Dr. Kernberg: And what has he explained to her?

Amy: He just says he is not going to do that. I think he thinks it’s her problem. I think he’s afraid, really, but he pushes it off on her, saying that...

Dr. Kernberg: Afraid of what? He thinks that he’s going to be blamed?

Amy: Yeah, or somebody will say they think there’s something that
maybe he needs to work on. That he may be contributing to some of the issues.

Dr. Kernberg: So there’s also a lack of responsibility or interest in him for her?

Amy: Yes.

Dr. Kernberg: And she has reason, then, to complain about that. Have you talked with her about that and how she should deal with him in this connection?

Amy: Oh yeah, we talk a lot about that, yeah.

Dr. Kernberg: What was she supposed to do with him about all of that? I mean, has she thought of sitting down with him and telling him, “Look, my therapist wants to talk with you because she’s trying to help me. That’s something you are doing for me. It’s not a matter of you being accused of anything. You don’t need to worry about anything. I’ve been very honest with her about what’s going on at home, and she feels she could help both of us, and I think, and that’s what I’m interested in. So what does it mean that you’re not—Are you not interested that our relationship should get better?” Has she done that, what I’m just saying?

Amy: I mean, I haven’t been there, but we’ve talked about asking him in. But I think if she focuses is it more on “this is to help me,” he may be more receptive to that. She has done that, but maybe she hasn’t emphasized that enough with him, that it was really to help her.

Dr. Kernberg: So what I was kind of illustrating is not a point that she has reached.

Amy: No.

Dr. Kernberg: Is that a fair statement?

Amy: Yes.

Dr. Kernberg: So it seems to me a first task of the treatment is to get her to reach a point where she can address the husband in this way, asking him for help with their relationship rather than blaming him for whatever is going on. That would be one objective.
Amy: Yes.

Dr. Kernberg: Is she aware that she suffers from a severe sexual inhibition?

Amy: Yes.

Dr. Kernberg: Is she worried about that?

Amy: No.

Dr. Kernberg: Why not?

Amy: She just states that she doesn’t want anything to do with sex. She’d be happy if she never had sex for the rest of her life.

Dr. Kernberg: Yeah. Is it an issue that should be taken up in the treatment, or should it be left alone?

Amy: I think we’re trying to take that up and exploring what has caused such significant aversion to it.

Dr. Kernberg: Well, we know that.

Amy: Yeah. But in an ongoing manner, the issues with her husband, I think she feels like she’s kind of reliving that. And she says she feels like a little girl again, then, when they become sexually involved. And so, we’re really trying to work on her awareness of what’s happening and for her to stay present as an adult, versus reverting back to feeling like a child in that situation, who’s powerless, but as an adult who can engage with him as an adult.

Dr. Kernberg: So a major issue is that she tends to treat him as if it were a continuation of her childhood, as if he were her father.

Amy: Absolutely.

Dr. Kernberg: Rather than accepting the reality that it’s a different man, a different time of life.

Amy: Absolutely, yes.

Dr. Kernberg: And is she aware that she’s doing that?

Amy: Yes.

Dr. Kernberg: And what makes her do that?
Amy: That may go back to the secondary gain that you were talking about. I think that, by doing that, that leaves her as the victim again, and then there may be secondary gain from that.

Dr. Kernberg: It leaves her as a victim, but why would she want to be a victim? It seems to me that behind that there may be deep feelings of guilt, both because of the possibility of having a better relationship than obviously her parents had, and she in her own childhood—not daring to have a better relationship with her husband than where she comes from.

And because of the unconscious sense of triumph and enjoyment that she may have had as part of the sex with father and the sexual experience in the childhood, one aspect of her sexual abuse and traumatization is profound feelings of guilt because unconsciously of breaking down of the Oedipal barriers is also a triumph. And we usually neglect the reality of infantile sexual life. So there may be many sources of unconscious guilt.

Amy: Yeah, I mean, we’ve talked about that. She has huge guilt about—And in fact, she says that there were times where she would go to her father and initiate that contact. And especially as an older teen. Then there’s huge guilt about that. That, “I asked for it.”

Dr. Kernberg: Yeah, so it is as if she now had to expiate the horrible behavior, as she sees it, by denying the importance of all sexual relations, right?

Amy: Yeah.

Dr. Kernberg: And by dismissing your pointing this out as a problem.

Amy: Can you repeat that?

Dr. Kernberg: Well, you point out to her that she has a problem with her sexual inhibition. She says, “No, I love it.”

Amy: No, she has a problem with it, because people continue to ask her for sex and she doesn’t want it. She just wants them to leave her alone. That’s what she would say.

Dr. Kernberg: Of course. I’m talking about the fact that her not wanting to have a normal sexual life, like an adult woman would, is a
problem. Or you don’t see it that way?

**Amy:** No, it is.

**Dr. Kernberg:** Have you pointed this out to her, or not really?

**Amy:** I don’t think in that way, no, I haven’t.

**Dr. Kernberg:** Okay. So in a way, you have accepted that she’s a woman who thinks sex is totally unimportant.

**Amy:** I don’t know if I’ve accepted it, and I don’t want it to be that way for her. But at this point, for her to think about it being a positive experience, that’s overwhelming to her.

**Dr. Kernberg:** Yeah, that’s interesting. Why do you think that might be overwhelming to think, “My god, sex can be a great experience. All other adult women enjoy sex, and I don’t. My therapist enjoys sex, and I don’t.” Could that generate an intense sense of envy and resentment?

**Amy:** Yeah.

**Dr. Kernberg:** It could. And from that viewpoint, her saying I don’t want anything to do with this protects her from envy and competition and permits her to stay in a position in which she’s a victim, which has an advantage of moral superiority, eliminates all guilt, invites others to take over. That might be a line of intervention. You have come a long way with her, and she has been able to maintain a very stable relationship with you.

**Amy:** Yes.

**Dr. Kernberg:** Perhaps this may be the next phase of the treatment and may help to improve the relationship with her husband, which looks like her main problem in life. And if secondary gain about the symptom can be eliminated, it may be that the pain can be taken care of as well. I think we are in time, and have to stop.

**Amy:** Okay.

**Dr. Kernberg:** Thank you for presenting this difficult case.

**Amy:** Thank you.

**Dr. Kernberg:** One final comment. Of course, she uses the reality of her terrible background to stay away from her own present conflicts
and participation in the difficulties she has with her husband. Tactfully, she may have to learn that her past should stop being a passport to get away from how she’s contributing to her present problems.

**Amy:** Yeah, I think that’s been the frustration for me. So it’s helpful to hear your comments.

**Dr. Kernberg:** It seems to me that that’s all I can say in our limited time.

Now I’d like to invite you to raise question, comments, criticism.

**Annie:** I just want to acknowledge you for what looks like great work with quite a complicated case. And I got curious when you were talking about when she first met this woman and also her husband at the beginning of romantic dynamic. Did she feel any attraction? Was she aware of any sexual inclinations at all? And you know, just curious if you ever asked that and what came up.

**Amy:** She may initially, but she will shut that down right away. And that’s how she’ll describe it to me, as well. She’ll say that she just wanted to sit and cuddle. That’s where she gets the enjoyment, is from the physical nurturing, and she would just as soon have it stop there. But the other woman then would initiate more sexual contact. So I think there is some initial, but then that probably scares her, and she shuts it down.

**Annie:** Yeah, I got that. I’m just wondering if anything was blown on those little embers to sort of bring them up, to magnify them, and what came out of that.

**Amy:** Okay.

**Annie:** Like, was she aware at all of, “I’m excited. I like this”?

**Amy:** Yes, she was. Yes.

**Annie:** Yes, she was, so it’s alive there somewhere.

**Amy:** Yeah.

**Annie:** Okay, cool.

**Steve:** This seemed like a very difficult case on so many levels with
the kind of stressors in her life and the context she grew up in, and now the challenges with her children and her husband. You talked some about sort of your work with her, and I just am wondering, in following up with what you said, the ideas you have about the transference and how she’s thinking of you, and what kind of feelings she’s had about you throughout the course of the treatment.

Amy: That’s a very good question, because, a lot of times, she will just come in, it feels like she dumps everything on me and says, “Well, you’ll know the answer,” or, “You figure it out.” You know what I mean? And so, there’s a lot of, like I said, “Here, I’m the victim.” and “Here, I’ll give it over to you, because you’re this perfect person where you know everything, and you’ll give me the answers, and then it will be fixed.” So there’s been a lot of that. Although, at times, she’s gotten frustrated with me, as well, and she’ll say, “I hate you.” You know, there is a lot of, “Here you go. Fix it for me.”

Steve: I’m interested in your ideas about the transference in this case.

Dr. Kernberg: Yeah, I think your question is a very valid one that is a very important point. I had not addressed the question because I assumed that it was a treatment that would not deal with transference interpretation. But even in such a treatment, you’re absolutely right. It’s important to look at the relationship and the extent to which it can be utilized to foster a therapeutic encounter.

It sounds as if there the patient has been able to maintain, in general, a positive relationship and seeing the treatment as a kind of a learning situation in which you are paid to help her find solution to her problems. You know it all. She accepts that, and she learns from you what she wants to learn and discards what she doesn’t want to, and feels supported. So this kind of learning situation, so to speak, in which she can learn issues and is free to accept some and reject others, permits her a safe dependency and may also have a function in permitting her to depend on one person in contrast to the refusal to establish a closer relationship with her husband. So it’s replacing, to some extent, positive aspects in the marriage.

I think that in this kind of treatment, it’s reasonable to maintain this relationship and use it as much as possible to improve her
relationships outside the treatment situation. In psychoanalytic psychotherapy, I would proceed with transference analysis and try to get at the deeper root of the problems by analyzing primitive transference developments in the psychotherapy. But that would require some minimum two sessions per week in addition to a different general strategic and technical arrangement. So I accepted the nature of the treatment, a supportive, reality-stressing treatment, whether it’s within the cognitive behavioral or within a psychodynamic frame. Supportive psychotherapy from a psychodynamic viewpoint and cognitive behavioral one regarding major life problems overlap in many ways, and I was trying to deal with that within that perspective.

With the exception of what I said about that strange, how shall I put it, collusion or tacit acceptance of therapist and patient that her sexual inhibition should be left alone. I question that, and that may lead to having to ventilate some problems in the relationship that are now underground. She can protect herself against any painful comparison with the therapist as an adult woman who presumably has a much healthier life from marriage than she has.

Okay, well it seems to me that we are ready to go to the next case. Let’s proceed.

**CASE 2: DON’T IGNORE THE PRESENT**

**Dr. Kernberg:** I understand Steve, you are going to present a case now? I’m ready for that. Go ahead.

**Steve:** Okay, great. Well, I want to talk with you about a patient that I’ve been seeing for about four months. His name is Tom, and he was referred to me by another psychologist who is in the same office suites that I’m in. When she referred him to me, she described him as very narcissistic and unable to see really basic problems in interpersonal relationships, and thought that he would really benefit from treatment.

Part of what she brought him in for was that she was seeing the patient’s wife, and she had been having lots of difficulties with him because of some conflicts he’s had with his extended family over the past several years. So she thought that, because he couldn’t appreciate
how difficult it was for his wife, that he would benefit from treatment. So that’s how he got referred to me.

So I met with him for the first time, and he said that, yes, he would like his relationship with his wife to get better, but really went on to talk in a lot of detail about his family origin and what turned out to be just an extensive history of conflict and difficulty and feeling like he’s the black sheep in the family.

So what he went on to describe was that about seven years ago they were—he and his wife were at a family function, and his mother made a very disparaging comment about his wife’s mother. And that was about all that the wife could tolerate. She had seen this family conflict for years. And so she said, “That’s it. I’m done with this family.” And it upset my patient, and he too had very little contact with the family over the past several years.

A couple of months prior to my seeing him, he received an email from a brother who had said that “it’s time to put all this behind us and let’s make some resolution.” So that initiated then a lot of concerns on his part about, “how do I—Do I want to reconcile and what do I want from my family?”

Kind of cutting to the chase as far as the sort of where I’m looking for some help is that my patient has been very accommodating as part of treatment. He’s on time. He participates. He’s there once a week. And while he initially talked about his conflict with his wife, I’ve heard for just about every week a lot of details about the dynamics of his family, both—and this is his extended family now, his mother and his brothers—and telling me about the conflicts they’ve had over all the years, and his reactions to his mother and to his brothers, their reactions to him.

And now we’ve had 15 or 16 sessions, and I’m hearing a lot of the same stories and the same kind of phrases that are used over and over again.

He will start to talk about things that have some emotional relevance to him, and I will observe that to him, which he seems to take interest in and think a little bit about it. And he will have that carry over from week to week. But I’m struck mostly by his ongoing need to repeat many of the same things that happened and the same stories.
What I don’t know is about a lot of this man’s life. I know a lot about how he feels towards his family and his family feels towards him, but I don’t know much about his relationship with his wife. They have a daughter who’s 12 that they adopted. I know very little about that. And instead, I have kind of ongoing repeated patterns of him sharing these situations with the family.

So I’m interested in sort of how to move beyond that. But in the bigger picture too, I’m also thinking about his narcissism and what level he would fall in from his personality organization. I’ve thought about him as being more neurotic but that these narcissistic issues come in. But the fact that he can’t talk about his relational world, and really his own inner world, that much, but focuses more on the stories of the interaction really make me do question his capacity to relate to others. So I’m interested in just your thoughts about him and moving this beyond the same patterns.

**Dr. Kernberg:** Well, my first reaction is, have you asked him about his present life? Have you asked him about his relationship with his wife, how they get along, emotionally, sexually, and other relations? Have you asked him about his work—how he gets along, how he relates to people, subordinates, superiors? About his present life, present problems, difficulties, symptoms? Why he comes for treatment? What he expects from treatment? Why is it so important? What’s going on with his family of origin? Why is that so crucial for him at this point? Have you asked him all these issues?

**Steve:** Well, some of those. Certainly, we’ve talked a lot about the family of origin and what he wants from them and why that’s important. But I haven’t asked much about the relationship with his wife, although, at times, when he starts to talk about her and his feelings towards her, I will acknowledge that and invite more. And inevitably, the associations lead him back to the family of origin.

**Dr. Kernberg:** But why haven’t you asked him more about the present? Why are you talking about the past when you don’t know the present? I’m asking this slightly facetiously because, of course, it’s a typical family disease of psychoanalysts. You know, through going to the past. It’s even worse with the Kleinians who only want to know what
happened in the first year of life, and the rest they’ll find out during the analysis. So they make diagnoses after long periods of time. A little of this, however, is also true for psychoanalysts in general. So are you suffering from a psychoanalytic disease?

**Steve:** I may have some of that. I will certainly acknowledge that. And I may have misrepresented this a bit, because a lot of his conversations…

**Dr. Kernberg:** No, I’m aware. I’m exaggerating. I’m trying to make a general point.

**Steve:** Sure. He does talk a lot about the current interactions among family members. And a bit of history just about that—that when he received this email from his brother—that was shortly before he came in to see me—and then he started to talk about, “Gosh, how do I respond to him? What do I want to say?” and “What do I want from the family?” And so, we talked at length about that. And then there were periods of weeks where he would send the email, he had sent the email…

**Dr. Kernberg:** May I interrupt you? I’m interested in the fact, that is, I’m asking you whether you have asked him about his present life. You are telling me, well, some, when what he’s saying permits you to do that.

**Steve:** Yes.

**Dr. Kernberg:** And it sounds as if he’s doing free association rather than being in a psychiatric or psychological evaluation in which I would raise questions and expect the patient to answer questions. And if the patient starts trailing off, I would say, “Well, this is very interesting, but I’d like to know…” Have you tried—are you doing an evaluation on the basis of free association, or have you done the more standard set of interviews of him?

**Steve:** When he came in, I did ask general kinds of questions that I think would be pretty standard about relationships and work. And I received, relatively brief but thought-out answers from him.

**Dr. Kernberg:** So can you tell me about this, what you have learned?
Steve: Well, what I do know….

Dr. Kernberg: Because you were telling me that he was talking about his past, but you were not telling me… I’m interested in his present life, always in the three major areas of love and sex, work and profession, social life, and creativity. And of course, to begin with, what are his symptoms? Does he have any? I’d like to have a full repertoire of physical symptoms, emotional symptoms, difficulties, in order to be able to make a diagnosis. I understand that he already came to you with a label of narcissistic personality, but you have not given me any further information that would go into that direction except perhaps that he’s controlling the interviews in some way. Do you follow me?

Steve: I do. Well, there’s a lot there you asked about. So I guess more to try to take it without kind of just his life history.

What I do know about him, with his work, is that he’s been quite successful. His work has been affected by economic difficulties in the state, and he’s retained his job and is actually sent on European trips.

Dr. Kernberg: What is he doing?

Steve: He does computer software engineering and works in a lot in a consulting role.

Dr. Kernberg: He’s effective at his work?

Steve: He appears to be, right.

Dr. Kernberg: How is he getting along with colleagues, superiors, subordinates?

Steve: Well, what he’s told me, which is very little, is that things seem to be fine. That they interact on a day-to-day basis. But there’s an absence of a lot in terms of, I don’t know about extended conflicts. I don’t know about how he feels towards the people he works with other than, “Things are good.”

Dr. Kernberg: Have you asked him?

Steve: No, no.

Dr. Kernberg: Have you asked him whether he gets along with people
or not, whether he has any problems with coworkers, subordinates, superiors, whether he’s happy at work or not?

**Steve:** I have not asked that many questions, no.

**Dr. Kernberg:** Okay. My recommendation is to ask these things in great detail. Because that gives you a sense of his personality and personality functioning. Is he happy at work? Does he have any problems there? Is everything going well? Is it an area without conflicts, problems, and issues? Can you tell me?

**Steve:** I can’t tell you a lot about that, actually.

**Dr. Kernberg:** Okay, that’s important, first thing. Now, about the relation with his wife, does he love her?

**Steve:** That’s a good question. I’ve wondered that. He says that, but it’s in the context of, “My family is so difficult, and I really care about my wife, and I want to focus on her, and I want to focus on my daughter.”

**Dr. Kernberg:** Excuse me, I asked you whether he loves her.

**Steve:** I don’t know.

**Dr. Kernberg:** You don’t know. Have you asked him?

**Steve:** No, not explicitly.

**Dr. Kernberg:** Is it important whether he loves her?

**Steve:** Sure.

**Dr. Kernberg:** Would a narcissistic personality have difficulty in loving? So it’s an essential question. Do you mind if I ask you, why haven’t you asked that question? I mean, I know you know—if I ask you about narcissistic personality I’m sure you know everything. Why haven’t you asked? There’s something there that holds my attention.

**Steve:** Yes, well, you know, in listening to your questions and your comment about psychoanalytic disease, actually I do think I’ve sort of been enticed by following his thoughts and his thinking and his associations. And I’m working hard to hear what he’s saying and listen to it. But I think that that’s come at the expense of then really feeling like I know what this man’s life is all about. I hear his thought processes and follow associations and affects, but…
Dr. Kernberg: Okay. Yeah. How is his sexual relation with his wife? Do they have sex frequently or not?

Steve: I don’t know.

Dr. Kernberg: You haven’t asked him.

Steve: I haven’t asked him, no.

Dr. Kernberg: Okay, is he satisfied with his sexual relation with his wife? You don’t know yet.

Steve: I don’t know. Yeah.

Dr. Kernberg: Okay. Do they have things in common? Are they enjoying life together? Do they have common interests or not?

Steve: I think they do have some common interests, that they enjoy each other’s company, and enjoy cooking together. But again, I don’t know much else about them.

Dr. Kernberg: She wanted him to go into treatment because she has difficulty with him?

Steve: Right.

Dr. Kernberg: Has he talked about these difficulties?

Steve: A little bit, and acknowledges that, “Yeah, my thinking does—I do spend a lot of time thinking about my family.” And then…

Dr. Kernberg: Excuse me, what are the difficulties with his wife?

Steve: Well, they get into fights, verbal disagreements about the amount of time he’s spending thinking about his family. And so, she will, in fact, he was telling her something that his mother had said and she became enraged.

Dr. Kernberg: But that happened years ago.

Steve: No, this was just recently.

Dr. Kernberg: Oh, I see.

Steve: Yes, he had a phone conversation with his mother, and then—So he told me. In fact, most of that session was spent talking about his wife’s reaction. And the focus was on her reaction to the mother and
telling me the details of it, but not about him.

**Dr. Kernberg:** Okay. So you have just said that his wife has complained that he is all the time thinking about his family rather than dealing with her. Did I hear you correctly?

**Steve:** Right.

**Dr. Kernberg:** Has he said that he has this problem with his wife, that he can’t think about her because he has to think about his family?

**Steve:** He has, and usually those acknowledgements come up near the end of a session. Or, if they come up in the course of a session, his thoughts then go right back to something with the family.

**Dr. Kernberg:** Does he think it is a problem that he has, or that his wife is exaggerating?

**Steve:** No, I think he recognizes it’s a problem.

**Dr. Kernberg:** That he has a problem, he has a problem. He’s thinking too much about his family. It’s something unrealistic.

**Steve:** Right, and that he may be wanting too much from them.

**Dr. Kernberg:** Instead of being interested in his wife.

**Steve:** Right.

**Dr. Kernberg:** He’s saying that he’s aware of that.

**Steve:** Right. He’s recognizing that he may be expecting them to…

**Dr. Kernberg:** That he’s staying away from the relation with his wife thinking about his family is a symptom.

**Steve:** Right, right.

**Dr. Kernberg:** And he’s doing the same with you.

**Steve:** I think so.

**Dr. Kernberg:** Have you asked him to describe his wife to you?

**Steve:** No.

**Dr. Kernberg:** Okay. This is important because it indicates the syndrome of identity diffusion: if he has an integrated view of her or not. Narcissistic personalities have great difficulty in having an
integrated view of the people they’re closest to.

Have you asked him what he sees as a reason for treatment? Because his wife is sending him. Does he need treatment, and what for?

**Steve:** He believes he needs treatment, first of all, though, to understand how to resolve these problems with his family, and in a secondary but relatively minor interest in treatment is so that things at home get better. But it’s all been about the family.

**Dr. Kernberg:** Yeah, okay. So he has no physical symptoms, no sexual difficulties?

**Steve:** Not that he’s reported, no.

**Dr. Kernberg:** You have asked him, or not yet?

**Steve:** I have not asked him, no. But he hasn’t complained of…

**Dr. Kernberg:** Yeah. His mood, any problem with mood, self-esteem?

**Steve:** No, his mood seems to remain fairly steady and fairly stable. The only time I’ve really seen affect, really, in a more intense level, was when he described his wife’s reaction, and he did so in a more intellectual kind of way. But as we worked through and thought about the process of what happened, I did see him getting more and more angry. And I do hear, then—A thought that came and went through his mind was, “Well, maybe we should get divorced.”

**Dr. Kernberg:** Oh, he has been thinking about divorce?

**Steve:** It’s come to mind, yes. But he’s only told me that in that one time, yes.

**Dr. Kernberg:** So it doesn’t look like a very close relationship, does it?

**Steve:** It’s not as good as it could be, is it? Yeah.

**Dr. Kernberg:** Not as good as it could be. Does he have close friends?

**Steve:** I don’t think so.

**Dr. Kernberg:** Have you asked him?

**Steve:** I have not asked him, no.

**Dr. Kernberg:** Okay. Well, it seems to me that you haven’t really done a thorough exploration of him at this point, and that he has managed
to seduce you to talk about his family, same thing that his wife is complaining about. But it has been facilitated, if I may say so, by your going along with this as if you were interested in his associations rather than in doing a thorough mental status examination. That is a problem.

Now, I do acknowledge that there used to be a tendency in psychoanalysis, particularly within the ego psychological tradition, to do a kind of a psychoanalytic interview in which the patient was asked to talk about whatever he wanted to and the analyst made an effort not to ask too many questions, in order not to disturb the transference, in order to learn as much as one could in an initial interview, and then put the patient on the couch and continue listening. And gradually, there was a hope that the diagnosis could emerge.

Of course, then people realized that some of the people who were put on the couch had very severe illnesses and couldn’t be analyzed, and it became a disaster. And I think that that tendency of using such an associative interview has been abandoned, even in most ego-psychological institutes. At the bottom, it was a consequence of the artificial separation between psychoanalysis and psychiatry.

I think that a very accurate diagnosis of the present symptoms, personality, identity, motivation for treatment, permits to really decide: what’s the definite indication, and what’s the motivation of the patient to increase it? And it sounds as if this is really the process that would seem to be indicated. And that there is indeed a transference development. Actually, I would like to hear your views about this, but it sounds that he is intelligently managing to seduce you to talk about his family and keeping a kind of a veil over his present life situation, if he has any awareness of himself psychologically. I’m not yet aware of that.

Steve: Right.

Dr. Kernberg: What are your thoughts about what I’m saying?

Steve: Sure.

Dr. Kernberg: Feel free to disagree. I’m aware I’m presenting a different viewpoint.
Steve: No, actually, no. Your questions are very helpful to me, because it is making me realize that I have been sort of seduced by this family story. And as he’s talked about his mother and his father and his brothers, there’s all kinds of rich analytic ideas that are coming up and come to mind.

But as far as sort of transference phenomenon, I do think he has a positive transference to me and a good working alliance with me. His father and his mother are interesting. His father is now deceased, and for most of his life his father was very critical of him. And at one point, actually got so angry with him and hit him in the face.

The patient had a history of substance abuse and got involved in substance abuse and using alcohol while growing up. And he was the oldest in the family, and his parents just really reacted very strongly to his substance abuse. I see that, though, as his reaction to their over-controlling ways and their kind of abusive relationship.

Dr. Kernberg: The substance abuse stopped?

Steve: Yes, he received a DUI when he was 21, I believe, and entered into some treatment and participated in a 12-step group, and has been sober 17 or 18 years.

Dr. Kernberg: So he’s not drinking, not smoking, not on any drugs, no medication?

Steve: No, right. But what he described with his growing up was that both parents were very critical and controlling. I mentioned the instance with his father where he was struck.

But as he worked his way out of his alcohol and drug abuse, his father and he seemed to reconcile. And the biggest contrast that I see is that, as he was growing up, in a time when he would kind of adapt a more bohemian kind of appearance and lifestyle, and his father made very pejorative comments about his physical appearance at that time.

But then, after this, he got sober and started to turn things around. His father actually recognized this and spoke very positively about him, said, “How proud I am of you for doing this.”

His mother, by contrast, is someone who is very controlling and still is. He says that he and his brothers all learned that you don’t ever
question Mom because she will make it very clear that she’s right and they’re wrong. And that, to this day, one of the things I hear about, I’ve heard probably four or five times is how his mother said to him, “You think you’re smarter than me, but you never will be.” And that’s something that has stuck with him for all those years.

So you know, I think that, in the context of the transference that it is. I think I am, you know, a good father and that father later in his life. But I think he keeps a very—himself quite distanced from me, from getting too close, for fear I might react to him in the way that his parents did, in a very critical and rejecting kind of way.

So I think that I’m getting sort of enticed into the story of his life and his relationships, but it’s getting very clear to me that it’s also keeping me at a distance from really knowing who he is and what his life and his world is really like. I just know...

**Dr. Kernberg:** Keeping you at a distance from what his present life is like?

**Steve:** Right.

**Dr. Kernberg:** Okay.

**Steve:** And really knowing him more as a person. I don’t feel that—one of my reactions to him is that I don’t feel like I really understand who he is as a person. I understand that he’s a man who has a lot of conflicts with his family of origin, but I don’t feel like I know much else about him.

**Dr. Kernberg:** Yeah, well, but that’s natural because he’s managing to get you away from asking the questions that would give you the information. And if he didn’t answer those questions, there would be a moment of truth. Right?

**Steve:** Right.

**Dr. Kernberg:** Okay. And his relation with his brothers?

**Steve:** Very contentious. They’re all younger than he is.

**Dr. Kernberg:** He’s the oldest?

**Steve:** He’s the oldest. I think, actually, he recognized that some of
the things that his mother and father would say just were not accurate representations of the world or life events, and he would stand up to them, and he would get very criticized for that. I think his brothers saw that and became very passive and submissive to the parents. So they all think that he is the black sheep and that Mom is a very sweet person and a loving person. But he sees her as much more manipulative and conniving. So it’s been a contentious relationship with them, and I think they still continue to see him as sort of a black sheep.

Dr. Kernberg: A black sheep because he criticizes Mother?

Steve: Well, more so from the substance abuse. Even though he’s been sober for 17 or 18 years, they really don’t acknowledge the success that he’s had by overcoming pretty intensive substance abuse. So they will be—He described an event several years ago where the brothers were sitting around and…

Dr. Kernberg: So they depreciate him, is that…?

Steve: Yeah.

Dr. Kernberg: So they depreciate him and Mother depreciates him. The only person with whom he has a good relation with is Father.

Steve: Right.

Dr. Kernberg: So why does he relate to them? Why doesn’t he send them to hell?

Steve: Well, this has been sort of some of my more analytical speculation about…

Dr. Kernberg: Have you asked him?

Steve: No.

Dr. Kernberg: Do you have difficulty asking him questions?

Steve: No, actually, I find him quite engaging. I think your questions are making me realize he’s really good at coming in and talking and getting me interested in what he has to say, but now that it’s been four months into it at once a week, I’m seeing, you know, I have gotten caught up in this and now I don’t know this man.
Dr. Kernberg: So he has managed somehow to manipulate you effectively.

Steve: Yes.

Dr. Kernberg: Is that a fair statement?

Steve: To the extent that I don’t really know a lot about him, yes. That’s how I would describe it.

Dr. Kernberg: And to the extent that you are unhappy with it and that you would like to know more, and that you haven’t raised the question that I’m sure you raise with other patients. Am I right?

Steve: Right.

Dr. Kernberg: Do you do the same with all your patients? You don’t ask him about the present life and go for four months only talking about their past?

Steve: No, I wouldn’t say it’s like that with all my patients. But I do think that I do tend to listen to where they are and try to follow their associative thinking and probably have not asked as much about the present life.

Dr. Kernberg: In general.

Steve: In general.

Dr. Kernberg: So there’s something about your style. So I would say there’s something problematic about your style. I hope you don’t mind that I’m saying that, but it may also be the culture in which you are developing as a therapist. I don’t know to what extent there is, shall we say, a kind of more traditional ego psychological culture in your institute? I’m not sure about it, so I don’t know to what extent. That’s something, in any case.

In any case, I suggest you think about that. It may be that you are—that I come in as a consultant from a different world and that you have to take with a grain of salt what I’m saying, and perhaps get the view of other consultants as well, because it’s an important issue: general style of evaluating patients.

But in any case, this patient has a capacity, then, to be seductive
and perhaps somewhat manipulative, and prevent you from getting knowledge that you would like to get. And under these circumstances, I’m a little puzzled by your saying that the transference is positive and that there’s a good therapeutic alliance. Is it a pseudo-submission and a seduction rather than a positive transference and therapeutic alliance?

**Steve:** Well, I say it that way because, you know, he is responsive to what I say to things, and when I’ve observed affect, and when I’ve observed the conflict he feels about what to do with his family. He really does stop and think about it and contemplate it. So I feel like he’s quite interested in what I have to say.

**Dr. Kernberg:** Okay. So it may be that if you raise all the questions about the present and really try to confront them—why is he coming for treatment, why is he stuck with a family that he doesn’t like, I mean, that he doesn’t love—you will have the answers?

**Steve:** Yes.

**Dr. Kernberg:** And then, on that basis of those answers, you can make your own diagnosis whether he suffers from a narcissistic personality or not. I don’t—I mean, he’s being called that by the therapist, by your calling the therapist of his wife, who doesn’t know him personally. And sometimes when we see only one person of a couple, we get a vision that changes when we know the couple. And you have to make your own diagnosis. I think that goes for all cases. Even if Freud sends you a case, I would do a diagnostic study. Freud made mistakes too, may he rest in peace.

So I think this patient still needs an evaluation about his reason for treatment. Does he have a narcissistic personality? And if he has a narcissistic personality, does he have an indication for psychoanalysis? Because he may be functioning so well that dealing with the concrete over-dependence of his family in a more focused way may be all he needs. In other words, a psychoanalytic psychotherapy dealing with overdependency—some problems in the relation with a family that can be taken up in the transference as well—a focused psychoanalytic psychotherapy rather than analysis proper.

While if, on the other hand, he has serious problems in all his relations
of which he may not be aware and that are seriously impoverishing his life and even threaten his marriage—that strange little thought about divorce, and the wife is unhappy—that may very well be an indication for psychoanalysis.

If his narcissistic personality were severe enough to have an indication for psychoanalysis, I wouldn’t see any contraindication for it. He’s functioning very well. He’s clearly not overtly borderline. He has no antisocial features. That, at least, you would know. Have you asked him whether—Now, in all narcissistic personalities, I would ask about antisocial features because they’re frequent. There certainly is no major secondary gain from treatment and no major direct aggression, and I don’t see an indication of major superego pathology. So, so far, it looks that he wouldn’t have any contraindication for analysis if the severity of the narcissistic personality would warrant it. And that I don’t know yet.

If the severity would not warrant it but there’s a concrete problem, excessive dependency on this family that can be controlled with a limited kind of treatment, that would be all of it. And sometimes, it is a conflict between the—it is a marital conflict.

It may be that both are contributing to an excessive dependency on his family of origin. The wife may be contributing to that in some way. Why is it so important what her mother-in-law said? Send her to hell. And if she can tell the husband he can visit them but they don’t come to the home, period. And we don’t talk about them anymore. I mean, there are many ways, many ways to skin a cat. And sometimes, marital therapy may improve the marital situation. Not everybody who fits on a couch needs analysis. So I can’t tell. I think this is the time, I’m a little concerned whether you may have experienced me as too critical. I’m very serious about that.

Steve: I appreciate those concerns. No, I don’t think so. I think you’ve really helped me get clear about the need just to ask some more questions. And I do think one of the things that happens for people who practice psychoanalytically, like you said, I think it’s so easy to work on following certain associations that you can be, four months into once a week now and I haven’t asked the right questions. So what
you have said has been very helpful.

Dr. Kernberg: Yeah. One more thing. During an evaluation, I try to see patients more frequently. In general, I try to see them twice a week to get, as soon as possible, to answering all the questions and then make a recommendation to the patient. And once I give a patient—let’s say a patient enters analysis—once I give instructions to doing free association and explain the patient’s task, my task—the patient’s on the couch, I’m sitting behind him listening—I go with the patient’s associations. So then I apply standard psychoanalytic technique, but not during the evaluation of the patient.

And regarding the critique, that if you become too “active”—that used to be the old-fashioned question of the diagnostic interview. I think the response to that is that as long as your interventions are technically neutral, you try to find out what’s going on, but don’t move the patient in one direction or another. You just ask questions. Why this, why not, what do you think? As long as you remain technically neutral, it doesn’t affect the nature of the transference. Although, of course the patient has a transference reaction to the evaluative process that then shows up in the early sessions and can be interpreted. May I ask whether you have a supervisor on this, or this you’re doing privately in your office?

Steve: This is private in my office. Right.

Dr. Kernberg: Okay, because if that were a part of a supervisory process, I would suggest that everything you’ve discussed with me also discuss with your supervisor. So get different views and then reach your own conclusion. But in this way, you have to use your own judgment and get to your own conclusion.

Okay, I think that we have reached the time, and maybe now it’s time for the rest of you to express comments, reaction, criticism.

Amy: I have a question I’m kind of curious about. If this is a client who potentially has narcissistic tendencies, why would he then want to be focusing on the past and talking about some conflicts versus focusing on how, maybe, successful he is at his current job? Do you know what I mean? It almost feels like he’s bringing up some places where he might have been like a failure, or had failure experiences,
versus more of talking about all the positives in the present.

**Dr. Kernberg:** Yeah, it’s a very good question. And that’s precisely what I would ask the patient. Not, why are you talking about the past instead of talking about your present successes, because we don’t know whether he feels his present is successful or not. He’s talking about the past because, for some reason, he’s avoiding to talk about his present life. We don’t know what reasons. And that’s precisely a question I would raise. And the way to raise the question would be, I would ask him very focused about the present. And I would see whether he gives me answers about the present. And if he does, it turns out that he was simply thinking that, as his major concern is his family, that’s what he should talk about. It may be a simple misunderstanding or that he’s avoiding an important issue in the present. And if once I’ve discovered that, that he’s very reluctant and even though I ask him, he’s not coming to that, then, of course, I may start raising the question with him.

“It sounds as if you have difficulty of talking to me about what’s going on in your life. What are you afraid of? Why can’t you talk freely about what’s going on?” And then we are in, in what’s going on. I cannot tell in this case which way it is because the therapist, Steve, has been going along with him.

So we don’t know that. But that this is a problem of the patient is also clear. I don’t think this is only a problem of Steve. There may be issues of Steve’s technique, but it is also a problem of the patient. The reason I’m saying this is because, in the interaction between Steve and me, I don’t know whether you noticed that several times when I asked Steve a question about the present, Steve talked about the family of the patient. In other words, Steve repeated with me what the patient is doing with him. That’s called parallel process, and usually it indicates that the therapist is aware of a problem emotionally but doesn’t have it resolved.

So it indicated to me that Steve was aware of a problem in the patient, that it was not simply Steve’s technique. But Steve, in his countertransference, was—And of course, Steve also said at the very beginning, I have a problem with this patient because he only talks
about the past. And I think the problem is much greater than Steve thinks it is because it repeated itself in the relation with me.

**Amy:** It’s the same thing that Steve said, that the wife and he talk about is the past as well. So this is another...

**Dr. Kernberg:** Yeah, yeah, of course. It also repeated, of course, what the patient is doing with his wife and the reason why she indicated treatment. So it all fits together and shows us what the next step is in the evaluation of the patient.

**Amy:** So I’m just curious why he’s even talking about that at all. Although it’s a pattern, why has he not then talking about some things he perceives as successes in his life? Do you know what I mean?

**Dr. Kernberg:** Why he’s not talking about success in his life?

**Amy:** Unless, he doesn’t feel like there are any, but if we’re talking about a narcissistic person, I would think he would be coming up with something that...

**Annie:** We don’t know he’s narcissistic.

**Dr. Kernberg:** We don’t whether he’s a narcissistic person and we don’t know whether he’s so successful in his life. We don’t know yet. We have to ask. The first thing we have to do when we don’t know something is to ask.

**Annie:** So that’s the thing I’d like to ask. That’s something that I’m curious about, is the role of curiosity when you’re sitting with a patient. I’m just wondering what your opinion is about how much of your curiosity you let inform the treatment.

**Dr. Kernberg:** My curiosity influences me enormously, and I’m terribly curious.

**Annie:** Where do you curb, if ever, your curiosity?

**Dr. Kernberg:** I never curb it.

**Annie:** Exactly. Okay.

**Dr. Kernberg:** I never curb it. Why should I curb it?

**Annie:** Exactly, that’s how I work.

**Dr. Kernberg:** Why should I curb it? If I don’t know something that
seems important to me, I’m trying to hear about it, to learn it.

**Annie:** Yeah.

**Dr. Kernberg:** Curiosity is never a problem if it—Well, let me say, if it deals with ignorance. But of course, if your curiosity is moved by some kind of hidden agenda and hidden aggression toward the patient, you want to know something to hit him over the head, that varies. Or, moved by an erotic tendency—you want to hear about his sexual life to get excited, then you have a countertransference problem. So if I have a sense that my curiosity is at the service of some emotional need of mine, then I start raising question internally. But that’s a difference. Other than that, if it’s simply a matter of knowing because I don’t have a complete awareness of what’s going on, I ask. Another—it used to be an old-fashioned psychoanalytic prejudice that you never ask a question because it influences the free association or something or the transference. That’s all silliness.

**Annie:** As long as you don’t have an agenda.

**Dr. Kernberg:** Yeah, well that has all gone down the river, thank god.

**CASE 3: SEXUAL INHIBITION AND PARAPHILIA**

**Dr. Kernberg:** Yeah, and speaking about curiosity, I’m curious about your case, Annie.

**Annie:** I’d like to tell you about my client, David. He’s a 41-year-old Caucasian male, single. He is actually a psychologist, PhD psychologist, and he currently works as an administrative assistant for his father’s company.

When he first came to see me, he was struggling with excessive masturbation, like six to eight hours a day. And this was a problem for him because it would get in the way of his work. He would be up late at night until two in the morning masturbating, sometimes. And his main complaint, actually, that he came in to me with is that he couldn’t—he was single. He’d never had sex in his entire life. He was a virgin. And he wanted to have a relationship. He wanted to be able to have an expressed sex life. And that’s something I specialize in, so he came to me seeking help with that.

The interesting thing about his situation is he masturbates, but not
to traditional pornography. What he masturbates to are images of women’s feet and a lot of YouTube videos of females doing karate tournaments—men being kicked in the nuts.

**Dr. Kernberg:** Men being?

**Annie:** Kicked in the nuts, in the balls. He has a ball-busting fetish. Okay? So female genitalia does not excite him at all. In fact, it revolts him. He was married for two years. His wife and him were never able to consummate the marriage because he couldn’t actually have sex with her. This was a problem and, as much as they tried to experiment with role play and ball busting, they still weren’t able to consummate, and she left him.

So there’s all kinds of issues around him. I mean, you can ask me questions as we go, but the main thing that we started working on was his shame: his shame about the fetish, his shame about his failed marriage, his shame about the fact that he was a virgin. So we worked through a lot of shame issues at first.

And the masturbation was a problem because, obviously, it was getting in the way of work. He wasn’t sleeping well at night, and it seemed that his esteem was in direct proportion to how often he masturbated. He was also part of a sex addiction group, a program that’s counted his sobriety as the number of days he could go without engaging in any sort of sexual act without a consenting partner, which included masturbation.

So basically, every time he masturbated to anything, he was failing at this program. And this program was the only social community he had. He’s quite shy, excruciatingly shy and socially maladapted.

So you know, these are the areas I starting helping him with, is opening his social circle, helping him with his shame, having him look at the level of his masturbation and see if there are other ways we could feed that need, and also just talking about the fetish itself, which he seemed to have discomfort about, that he had that fetish.

**Dr. Kernberg:** When you talk about fetish, what do you mean?

**Annie:** Ball busting. So he doesn’t actually enjoy sexual fornication. He only enjoys being kicked in the balls. That’s, for him, the sex act,
and that’s what he masturbates to and that’s what he craves.

**Dr. Kernberg:** So it’s a masochistic wish to be kicked in the balls?

**Annie:** Yes, by a dominant woman.

**Dr. Kernberg:** Yeah, but it’s not—that in itself is not a fetishism.

**Annie:** Okay.

**Dr. Kernberg:** Fetishism implies sexual excitement with either part of the body or an object connected with sex.

**Annie:** So the foot. That’s really—he’s got a foot fetish.

**Dr. Kernberg:** Yeah, so his excitement with feet, that has a fetishistic quality, but being kicked in the balls sounds more like a masochistic. So he has both masochistic and fetishistic wishes.

**Annie:** Absolutely.

**Dr. Kernberg:** Now, when he masturbates, does he have a normal erection? Does he get excited? Does he reach orgasm with ejaculation?

**Annie:** Yes to all of those. The only peculiarity he has about masturbation is he never touches his own penis. The only way he masturbates is to rub it on a folded towel or the edge of a desk, so another object outside of his hands.

**Dr. Kernberg:** Why doesn’t he masturbate touching his penis?

**Annie:** Up until he came to see me, it was just a habit. He didn’t have a reason. I asked him to explore using his hands and he did try using his hands and he seemed to be successful.

**Dr. Kernberg:** He was able to.

**Annie:** He was able to.

**Dr. Kernberg:** He had never tried that before?

**Annie:** I don’t know about in his early, in his youthful years, but over the last 10 years, that’s become his habit, using the edge or surface of something else to rub against.

**Dr. Kernberg:** But when he was married, did he try—it never occurred to him to masturbate himself and get an erection?
Annie: He could get an erection. He could even get as close to almost penetrating his wife, and then he would lose the erection as soon as the whole genital like, you know, of his wife was exposed. It’s almost as if that turned him off. He could maintain an erection if he’s playing, if she’s playing ball...

Dr. Kernberg: So he could maintain? And how did he get the erection in the first place?

Annie: The only time he was able to get an erection with his wife was when they started doing these S&M role-play sessions, which she was reluctant to do.

Dr. Kernberg: In other words, when she would kick him? I mean, kick him in the balls?

Annie: She would pretend to dominate him, and kick him in the balls but very lightly, not sufficient for him to get super excited. So even in their role-playing...

Dr. Kernberg: So when she kicked him in the ball he would get an erection.

Annie: Eventually.

Dr. Kernberg: Yes. But he could not penetrate her.

Annie: No.

Dr. Kernberg: Because he was disgusted by her genitals?

Annie: Yes. His words are “revolted.”

Dr. Kernberg: Yeah, revolted. He was disgusted by that. And did he try to penetrate her while she was covered, say with a skirt or something so that he couldn’t see her genitals? Did he try that?

Annie: I don’t know if he tried that. Basically, she reluctantly, maybe only once or twice, participated in this masochistic role-playing. She was kind of disgusted by that whole experience herself, so her lack of genuine enjoyment of it also contributed to their inability to make it work that way.

Dr. Kernberg: And did he ever try to go into S&M clubs?

Annie: No, he has never. Part of our working together was exploring
that and seeing what was possible.

**Dr. Kernberg:** Yeah, why hasn’t he? Why didn’t he.

**Annie:** Before meeting me, because of the shame. The fact that he even had this S&M predilection was not something that he would tell many people, was not something—He barely told his wife. You know, he was married to her for many many months before he even revealed that. That was when they couldn’t have sex.

**Dr. Kernberg:** Okay, and he had not—but it hadn’t occurred to him to go to an S&M parlor or place?

**Annie:** It might have occurred to him as a passing fancy, but he’s also excruciatingly shy, and so he didn’t know how to show up in that space. In work with me, that became something that we explored together.

**Dr. Kernberg:** Yeah, okay. And he’s also shy in his social life, isolated, has no friends?

**Annie:** Absolutely. He has work and then two social venues. He’s a hiker. He loves hiking. That’s his passion. He’s part of a hiking club. And he also is part of this sex addiction community. It’s a program, a 12-step program. And that’s the extent of his social life.

**Dr. Kernberg:** And that sex addiction program cut him off from the only sexual pleasure that he had.

**Annie:** Exactly. Yes.

**Dr. Kernberg:** What gave him the idea to go to that?

**Annie:** His ex-wife. His ex-wife required that he go. And because it became a community for him, it’s the only place where he’s known, recognized, and… One little story, up until recently, he’s been 120 days sober, which means he has not masturbated at all to any images. This he saw as a triumph and accomplishment because he got a lot of kudos from his community.

**Dr. Kernberg:** And he’s a psychologist with a PhD in psychology?

**Annie:** Yes, and not working with that degree at all.

**Dr. Kernberg:** Yeah, I know. Yeah, he’s not working at all as a
psychologist, but…

Annie: Well, recently, in the last 4 months in our work together, he’s been taking on some clients at a nursing home, some patients suffering dementia. He works with them and he’s been billing for them. So he’d been very dissatisfied at work. That was also another problem, not just the sexuality. And so we were working on that together as well.

Dr. Kernberg: He has been?

Annie: Very dissatisfied.

Dr. Kernberg: Dissatisfied?

Annie: Yes, yes, he’s a paper pusher and he doesn’t have any power in his job. He works at his father’s company, and he doesn’t get to practice his profession, which is what he enjoys doing.

Dr. Kernberg: Yeah, okay.

Annie: So the struggle…

Dr. Kernberg: And he has no social life.

Annie: Except for hiking. And, recently, we’ve been involving him in some dating opportunities and different social events. And he’d been starting to go on dates, and this has been a success. So there’s been recent changes in extending his social…

Dr. Kernberg: Is he interested in women?

Annie: Absolutely.

Dr. Kernberg: Has he ever been in love?

Annie: No, only recently has he even started accepting this part of his life, this sexual world of his making as, that someone could possibly love him for. He feels like that would get in the way of him being attractive.

Dr. Kernberg: Why did he marry his wife? Was he in love with her?

Annie: I actually don’t know if he was in love with her. She was an anecdote. It was at least—It was many years ago that he was married. So, you know, I’m pretty much focusing on where he is now.

Dr. Kernberg: Has he been involved with any woman since…
Annie: No.

Dr. Kernberg: He has been divorced from her for how many years, 10, 20, 30?

Annie: Yeah, at least five years, maybe more.

Dr. Kernberg: Okay, and no relation with any woman either before nor after that?

Annie: No, no before or after that. And definitely no sexual relationship. He was a virgin until he met me.

Dr. Kernberg: Has he ever been in sex therapy?

Annie: Not official sex therapy. That’s something—I mean, no, I don’t think so. He worked with a psychiatrist. He’s worked with—I don’t know. No, I don’t think he’s been in specific sex therapy.

Dr. Kernberg: He worked with a psych…

Annie: He worked with a psychiatrist.

Dr. Kernberg: He was in psychotherapy?

Annie: Yes.

Dr. Kernberg: How long?

Annie: I’d say probably two years, but he wasn’t involved in any of that when he first started seeing me. I’d say it’s been four years since he’s been in any treatment.

Dr. Kernberg: He has not been in treatment for the last four years. But when he was in treatment with the psychiatry, what kind of treatment was that?

Annie: All he would tell me about it was that he was made to feel more ashamed of his fetish. He was told that was wrong and needed to be suppressed and was interfering in his life, and so that shame just mounted, which is why I think he desisted from that course of treatment.

Dr. Kernberg: The psychiatrist told him that this was wrong and you should be ashamed?

Annie: I don’t know if his psychiatrist told him that. That was the
effect that he got from the treatment.

**Dr. Kernberg:** And how does he explain that he got that as an effect of treatment? Sounds strange.

**Annie:** Yeah, he basically describes all treatments he’s ever been involved with as not supportive of this quirk of his sexuality.

**Dr. Kernberg:** Yeah, okay.

**Annie:** And this is the first time he’s had it be...

**Dr. Kernberg:** Is he interested in men, sexually interested in men?

**Annie:** Not at all.

**Dr. Kernberg:** And he masturbates to pornography, visual pornography?

**Annie:** Not pornography. I’m calling it pornography, but it’s really just images of women’s feet and YouTube videos of women doing karate, so women kicking men in the balls. That’s what he masturbates to.

**Dr. Kernberg:** In other words, with sadomasochistic videos.

**Annie:** Yes, but specifically ball busting.

**Dr. Kernberg:** Specifically?

**Annie:** Ball busting. That’s the name of, you know, just...

**Dr. Kernberg:** Okay.

**Annie:** There’s another thing, that he really enjoys role play with large beasts. This is something he played with with his wife. Rhinos, hippos, and elephants he identifies with. He supports their charities, and he likes to take on a role play where he embodies one of these characters—a rhino or a hippo—and his wife would embody a particular marsupial called the wombat. It is very specific, and he would enact these encounters. And it was his way of showing affection. It was also a way he got aroused.

**Dr. Kernberg:** He would get aroused with her showing affection?

**Annie:** He would get aroused doing that role play.

**Dr. Kernberg:** Yeah, and then what did she have to do to hit his balls, to whip them, to compress them? How would she...
Annie: Kicking.

Dr. Kernberg: She would kick them.

Annie: Kick him, and quite hard. Pretty much, he never gets kicked hard enough. Almost, it looks like he would want damage. Yeah, he’s...

Dr. Kernberg: And so, if she kicked his balls hard enough, he would get an erection?

Annie: Yes, which was a problem, because she didn’t really want to do it.

Dr. Kernberg: So she did it disgusted.

Annie: Yeah.

Dr. Kernberg: Was she then trying to follow that up by his penetrating her, or not really? Was she too disgusted for that? She wasn’t able to participate?

Annie: If that’s what it takes, then okay. Let’s try it. But by the time he got to intercourse, her energy, the fact that she wasn’t into it, and the fact that it’s actual intercourse, which he is not interested in, would contribute to having the erection disappear. Now, his father used to constantly berate him, and one of the terms he would use is, “You need to be busted in the balls in order to get things done.”

Dr. Kernberg: Okay, it doesn’t excite him when he’s hit in other places?

Annie: No. He get’s marginally excited by domination behavior, like being told what to do, being forced to clean the dishes. He’s written out scenes that are his fantasies.

Dr. Kernberg: Yeah, but forced to do what?

Annie: So in the fantasy scenes he’s written out—his homework—he’s often being told by his fake girlfriend to go and make dinner out of punishment for misbehaving, or clean up.

Dr. Kernberg: Okay, go ahead.

Annie: So the issue I’m struggling with right now is we’ve got him to the point where he’s not masturbating; 120 days no masturbation,
which he saw as a triumph.

**Dr. Kernberg:** How long have you seen him in treatment?

**Annie:** Seven to eight months.

**Dr. Kernberg:** Seven to eight months. What frequency?

**Annie:** Once a week.

**Dr. Kernberg:** Once a week. And what’s your diagnosis of him?

**Annie:** You know, because he came to me primarily with wanting to be in a relationship, and that was his main concern, I eluded diagnosing him with anything. I was just trying to support him in making that happen. So it was only in my asking questions that I found out about all this sexual history.

**Dr. Kernberg:** Yeah, of course.

**Annie:** And I just keep trying to focus on what I can do to help him be less ashamed of his sexual predilections. I’ve helped him participate in fetish communities to see if he could find someone to at least explore that with and perhaps segue into actual intercourse, which we were able to accomplish. So he was a virgin when we met. He had one experience where he lost his virginity.

**Dr. Kernberg:** So you oriented him to an S&M community?

**Annie:** I introduced him to the idea to see what he thought. He seemed interested but hesitant because he wasn’t confident of how to approach it. So I supported him in how to approach it, and I think it’s sort of a Web forum where you can post a profile and look for people who will receive the other end of your fetish, masochistic experience. He found someone who is a dominatrix who he arranged to have a meeting with, and she participated in playing out a scenario fantasy that he had written out, and acting it out, which culminated in actual intercourse.

**Dr. Kernberg:** The dominatrix kicked his balls?

**Annie:** Yes.

**Dr. Kernberg:** And he had an erection?

**Annie:** And played out the whole scene.
Dr. Kernberg: Yeah, and he was able to have sex with her?
Annie: Yes. She had to keep her underwear on.
Dr. Kernberg: To penetrate?
Annie: With some criteria. She had to keep a skirt on.
Dr. Kernberg: Of course.
Annie: Yeah, no actual visual interaction with her genitalia.
Dr. Kernberg: But under this condition, he could penetrate her, have sex, maintain the erection, and ejaculate in her?
Annie: He wasn’t able to ejaculate in her.
Dr. Kernberg: Why not?
Annie: He pulled out at some point.
Dr. Kernberg: Why?
Annie: I think he was—Maybe he was losing the erection. I think he was losing the erection. He pulled out, and then she finished him.
Dr. Kernberg: She masturbated him manually.
Annie: With her feet. With her feet.
Dr. Kernberg: Yeah, he has no experience. He doesn’t know that hands can be used for masturbation, right?
Annie: And he knew that her feet would regain…
Dr. Kernberg: That the feet excited him.
Annie: Yes, and then he reached orgasm.
Dr. Kernberg: Yeah, she was good at her job.
Annie: Yes. Well, she was also schooled and vetted.
Dr. Kernberg: Yeah, a good dominatrix has to be a psychologist. These are sometimes very intuitive women.
Annie: Yes, she was. I met with her, actually.
Dr. Kernberg: You met with her?
Annie: I met with her.
**Dr. Kernberg:** Very good. So you really organized sex therapy for him.

**Annie:** Yes.

**Dr. Kernberg:** And is he continuing the relationship with her?

**Annie:** No, he’s not.

**Dr. Kernberg:** Why not?

**Annie:** Even though it was a successful experience, one of his character features is that he constantly reframes every experience as negative. So instead of that being a successful triumph and, “I’ve lost my virginity. I had intercourse.” He sees that as a failure because he didn’t actually ejaculate in her, so it doesn’t really count. “It didn’t really work. I don’t know if I’m really not a virgin anymore.” He’s only kind of just squeaking past the finish line. That’s how he frames it. And so, he also said she didn’t kick him hard enough. She didn’t stick to the fantasy scenario as much as he’d like. So he doesn’t want to see her again. But he enjoyed the experience sufficiently that he wants to try it out again.

**Dr. Kernberg:** So he has now a relationship with her.

**Annie:** Not an ongoing. It was a one-time experience. He does not want to see her again.

**Dr. Kernberg:** Why not?

**Annie:** Because she didn’t kick him hard enough.

**Dr. Kernberg:** And he doesn’t think that she could learn that?

**Annie:** He, for some reason, would rather try someone else. He wants to go into the fetish scene and meet someone perhaps with more experience.

**Dr. Kernberg:** Yeah.

**Annie:** This lady was acting the role of a dominatrix. I don’t think she was actually a dominatrix. She was like a sex therapist.

**Dr. Kernberg:** Okay, yeah. But in any case, so he’s trying to work on that.

**Annie:** Yes. He is open to going to fetish parties...
Dr. Kernberg: Yeah, okay, yeah.

Annie: The thing I’m struggling with right now though is, the only community that really supports him is this sex addict program community who only esteem him and give him kudos pretty much when he is going for many, many days without masturbating. So 120 days, he was at the top of his game. He was the star in the group.

Dr. Kernberg: But isn’t there a contradiction between his going to that community that’s anti-sex and, on the other hand, trying to learn to have some sexual gratification?

Annie: And this is where I’m stuck. I have—There’s a—This is where I’m stuck.

Dr. Kernberg: Do you agree with me?

Annie: Oh, absolutely.

Dr. Kernberg: Have you pointed this out to him?

Annie: Yes.

Dr. Kernberg: How has he reacted to that?

Annie: Because there’s still shame about exploring that sexual community and pursuing his sexual desires. There’s still—even though we’ve worked a lot with it—there’s still some shame. There’s no shame attached to being part of this program and climbing out of his addiction and getting the acclamation of the people in that community when he successfully abstinates from acting out.

Dr. Kernberg: You’re seeing him with what frequency?

Annie: Once a week. Sometimes he’ll skip a session if he’s on a vacation.

Dr. Kernberg: Once a week. And what is your general therapeutic orientation? Roughly. Cognitive behavioral, psychodynamic?

Annie: Yes, cognitive behavioral therapy.

Dr. Kernberg: Cognitive behavioral. Okay.

Annie: I’m more results-driven. I don’t spend a lot of time on the past. I’ve asked enough questions about his past to give context to his
current behavior, but I don’t linger in that at all. I’m really committed
to helping him have a relationship, have a fulfilling sex life, and…

**Dr. Kernberg:** You translate my asking you, as I come from a
psychodynamic background, that I must be interested in the past.

**Annie:** Maybe, I’m sorry about that. Yeah.

**Dr. Kernberg:** Yeah, it’s the psychoanalytic illness.

**Annie:** I’m obsessive in the other direction. It’s like past is an
addendum.

**Dr. Kernberg:** Yeah, actually, psychoanalytic psychotherapy with
severe personality disorders then. What’s your diagnosis of him, by
the way?

**Annie:** Well, he came—You know, one of the things…

**Dr. Kernberg:** Severe sexual inhibition, complex—

**Annie:** Anxiety disorder. He also has depressive tendencies.

**Dr. Kernberg:** What’s now called paraphilia--complex perversion
with sadomasochistic and fetishistic elements. So he has a sexual
perversion, now called paraphilia because they didn’t like the term
“perversion.” Yeah, and what else?

**Annie:** He suffers from anxiety disorder and bouts of depression. I
mean, while he’s been seeing me, he hasn’t been suffering depression.
But he has been diagnosed with depression and medicated for it
historically.

**Dr. Kernberg:** He suffers from depression?

**Annie:** When he came to see me, he told me that he had been
diagnosed.

**Dr. Kernberg:** But he is now not depressed.

**Annie:** Not while he’s been seeing me, and he’s not been on any
depression medication.

**Dr. Kernberg:** And he is on no medication.

**Annie:** Not while he’s been seeing me.

**Dr. Kernberg:** He’s not on any anti-depressive medication now?
Annie: No.

Dr. Kernberg: Very good, because you know anti-depressive medication inhibits sexual behavior. The last thing he needs.

Annie: Yes.

Dr. Kernberg: He’s not depressed now. How severely anxious is he?

Annie: His entire affect is comprehensively anxious. As soon as he comes—I mean, that’s just what defines him. He’s like a bundle of anxiety, constantly.

Dr. Kernberg: Yeah, he’s chronically anxious.

Annie: Chronically anxious.

Dr. Kernberg: But he’s used to it. He’s been like this all his life?

Annie: Yes.

Dr. Kernberg: Okay, is he getting any medication for the anxiety?

Annie: Not currently.

Dr. Kernberg: Good. Because he would end up, again, with anti-depressants, because benzodiazepines over a long period of time are not a good treatment for severe anxiety and people with significant—with severe—personality disorders. What’s your diagnosis regarding his personality? You have severe, diffuse, social inhibition, right? Or not?

Annie: Absolutely severe, diffuse, social inhibition, but I wouldn’t call him antisocial and…

Dr. Kernberg: No, no, of course. He’s not an antisocial personality.

Annie: I don’t see any borderline.

Dr. Kernberg: But does he have—Would you say that—And he is terribly shy, timid?

Annie: Terribly shy, timid.

Dr. Kernberg: Would you say that he has a schizoid personality?

Annie: I don’t see any evidence of that.

Dr. Kernberg: No?
Annie: No.

Dr. Kernberg: He’s hypersensitive to social contacts, terribly inhibited, doesn’t see any—doesn’t have any close friends, doesn’t have any close relationship?

Annie: He’s very close to his family. And in our dynamic, I feel, I’m not seeing anything in our dynamic that suggests he has social inhibitions.

Dr. Kernberg: Okay, so what is your personality diagnosis? You don’t have that?

Annie: I haven’t made a diagnosis.

Dr. Kernberg: Okay. I’m not sure, but I’d bet he has a severe personality disorder. I don’t have enough elements to say what type. Are there severely narcissistic features or not?

Annie: I don’t see any evidence of that.

Dr. Kernberg: He has no close friendships?

Annie: He does have some. He has his hiking buddies.

Dr. Kernberg: He has close—Does he have close friends with whom he meets all the time?

Annie: He has a few friends that he meets under the circumstance of going hiking, and they hike together. But outside of that dynamic…

Dr. Kernberg: But does he see them outside of hiking?

Annie: No.

Dr. Kernberg: Does he have any social life over the weekends? Does he meet with anybody? Does he see anybody?

Annie: He’s starting to now because he’s going to—But no, historically no.

Dr. Kernberg: So he’s very isolated socially.

Annie: Yes.

Dr. Kernberg: And his interaction with you, is he open, relaxed, direct? Or is he timid, shy, thin-skin-type of sensitive to your
comments and reactions?

Annie: He’s open and relaxed with me, but he’s very physically anxious in his gestures. Like, this is how he sits when he talks to me. And a lot of shame about his interactions with me, if he’s offended me. He’s worried about offending people in general.

Dr. Kernberg: So is there a childlike attitude about him, infantile, childlike, immature? I’m trying to make a differential diagnosis, but it’s not essential at this point.

Annie: I find him actually, in interacting with me, I don’t see any problems with why it would interfere with him having friendships. Like, he’s open. He’s honest. He reveals his inner life. He seems to have a strong moral sense.

Dr. Kernberg: He has a strong moral sense?

Annie: Yes.

Dr. Kernberg: You tell me. I know. I mean, this inordinate sense of shame, it’s totally absurd, kind of ridiculous. It’s a superego cathedral-sized, right?

Annie: Yes.

Dr. Kernberg: Okay. Your main focus on the treatment is trying to help him resolve his sexual problem?

Annie: I’m committed to helping him have a fully expressed sexual life. Also, at work, we’re working on him seeing patients, and that’s working well. He’s doing more hiking and exploration in his social life, so that’s working well. It’s just getting—He really wants to be in a relationship, and it’s depressing him to not have that.

Dr. Kernberg: A relationship, he means with a woman?

Annie: With a woman.

Dr. Kernberg: And does he think there has to be some sexual aspect, or does he imagine he’s going to be with a woman who is likely to be a good sister to him?

Annie: No, he wants to be with a woman who…

Dr. Kernberg: With whom he can have some kind of sexual relation,
so that his great difficulty is his sexual inhibition.

**Annie:** Yes, but he wants to be with a woman who can play the fantasy with him.

**Dr. Kernberg:** Okay. But the great obstacle is his sexual inhibition.

**Annie:** His sexual inhibition and this problem with—There’s an issue because this program is actually feeding more shame around anything to do with sex.

**Dr. Kernberg:** We’ll talk about this in a moment. Yeah, okay, we have very little time. I’ll go to then the dominant present issue as I see it on the basis of what you’ve said.

In one part of him, he wants to have a freer sexual life, and the opening he has is that perversion. The combination of sadomasochistic gratification if he can be kicked hard in the balls, and then a woman uses her feet or then he can penetrate her, he enjoyed the fact that he could penetrate her, then he can penetrate her and so far the feet finish him off. But he would like to ejaculate in the vagina. So he has all kind of concrete tasks. But in another part of him, he doesn’t want to have to do anything with sex and belongs to the religious—to the convent of the sex addicts, which is a non-existing diagnosis that is culturally fashionable. Do you agree with me?

**Annie:** Yes, I do.

**Dr. Kernberg:** Okay, first point. So he’s divided between one part of him that wants to get better, and one part of him that wants him to remain a slave to his sexual inhibition, and which is also a part of him that keeps him castrated in his profession. A psychologist who had to remain as a paper shuffler for his father and to even now has to go into some low-key, probably poorly paid position rather than daring to go into his own field. So he acts as if he didn’t have the right to be a full man. Fair statement? And I would point this out to him, that his going to that fetishistic—to this sex addict group, is fostering his illness and against his interest. Have you said this to him?

**Annie:** Absolutely and emphatically.

**Dr. Kernberg:** How does he react to this? Good for you. How does he react to that?
Annie: He recognizes it. He accepts it. He totally sees how it’s inconsistent with the work that we’re doing, and yet, it’s the only—It’s like the church of his community. And because most of his social alliances come from that world, and it’s the only place in his life other than with me where he’s being clapped for at all, he’s unwilling to relinquish that space.

Dr. Kernberg: Because he needs the social contact?

Annie: And the affirmation of—Yes, because he needs the social contact, yes.

Dr. Kernberg: Yeah, and what about having the social contact and masturbating as much as he wants to and having sex as much as he wants to?

Annie: Well, that’s what I’m trying to create with his social life and his hiking people and everything outside that. Getting him to disconnect from this program is being...

Dr. Kernberg: No, no, let’s say he doesn’t disconnect. I mean, it’s a crazy program. It’s a cult.

Annie: Absolutely.

Dr. Kernberg: So what about—He says the only friends are the friends of the cult. So what about trying to looking for a new friend, and for the time being, continuing friends with the cult without going through the rituals.

Annie: Which is what we’re doing. But there’s one more thing I want to point out. It’s not just the friends.

Dr. Kernberg: What about that approach? Would that work or not?

Annie: Yes, and yes, we’re doing that right now. And he’s actually exploring joining a new cult, which doesn’t make it wrong to masturbate.

Dr. Kernberg: Which is the new cult?

Annie: At least he can masturbate. This one doesn’t let you masturbate at all. That’s considered a breach of the program. This new cult allows you to masturbate, but as long as you’re not having sexual intercourse outside of a consenting relationship. That’s considered a breach.
Dr. Kernberg: But that’s more of the same.

Annie: I know, but I’m trading him…

Dr. Kernberg: I would tell him that a part of him is out to castrate himself. Whether he’s first society or the second makes no difference. And that part of him is rebelling against you and your efforts to help him. Is he aware of that, that he is dismissing your efforts to help him?

Annie: Yes, he is, and he’s ashamed of that too. He’s ashamed that he can’t…

Dr. Kernberg: That I would foster, is that he has good reason to be ashamed.

He is a supporter of this sadistic dictatorship in his mind that opposes his obtaining a road for sexual gratification that means the beginning of a road to having a relationship with a woman.

Annie: I have one more comment to make about this program that he’s part of. While he’s being sober, as in not acting out for 120 days, I have seen his esteem higher than it’s ever been while he’s been working with me. This is where I’m in a conundrum. He’s been going on more dates, been happier, been more jubilant while he’s been sober, which he claims the program is supporting him in doing, that I am stuck with this clear awareness that this is contributing to his happiness in life and at odds with this long-term work that we’re trying to do together. And this is where I feel stuck.

Dr. Kernberg: Yeah, well.

Annie: I wanted to cut off this program from him and really make that clear.

Dr. Kernberg: I would point out to him that his dating is, of course, very positive. But he has to pay the price of sacrificing his sexual life. It is as if one step forward always requires one step backwards, that he has to pay a price he can’t afford, to improving without, at the same time, setting himself back as if he felt guilty over the possibility of a more gratifying sexual life and resentful of you who are trying to help him. Because the fact that you are trying to help him is making him feel even more guilty, and that’s his problem right now in the treatment. Does that help?
Annie: Yes, that helps. Thank you.

Dr. Kernberg: Okay, I’m impressed by your dealing with the essentials. I think that’s just right and that a cognitive behavioral approach to begin with as you have carried out is a helpful way, although, as you can see, it opens up the psychodynamics of unconscious guilt of the need to self-castrate as a powerful motivation that prevents him from any sexual gratification.

Once he is freer to enjoy his perversion, one can then analyze the perversion as, again, paying a price for sexual enjoyment, being reduced to essential conditions rather than having the freedom of trying out other things. And the most typical manifestation of this is the inhibition of masturbating with his hands, which is the most typical form of normal childhood masturbation, that’s deeply forbidden and he’s trying to get around to.

And even without knowing anything about his background, I think he must have been brought up in the most sadistic anti-sexual atmosphere that one can imagine. His father probably was a direct relative of the Pope and his mother of the Chief Rabbi of Jerusalem, and he was brought up in a deeply Muslim home, right? All of these things together? Okay.

Annie: Any interventions you would recommend?

Dr. Kernberg: What I recommend is that you systematically analyze his not listening to you because you are trying to promote his sexual gratification and freedom, and he acts as if it were deeply forbidden—something in him does not permit him to enjoy sex. And he uses shame to rationalize his inhibiting his sex, and uses this crazy social environment to inhibit his sexual response, rather than seeing the relationship with that dominatrix as the first light at the end of the tunnel. Just the beginning.

Annie: Exactly, yes.

Dr. Kernberg: And his criticizing is trying to diminish something that’s on the road for achieving sexual gratification.

Annie: Great, we’re aligned, excellent.
Dr. Kernberg: Okay.

Annie: Thank you.

Dr. Kernberg: I’m sorry. We have to stop at the time. It has been a pleasure. And I hope that the pleasure has been mutual in spite of all the ups and downs.

Annie: Absolutely.

Dr. Kernberg: Thank you.

DISCUSSION

Victor: So those were three very interesting cases; quite different. And your focus on each case was quite different and flexible. And you certainly, I think for the viewers and even for me, dispelled—or further dispelled—a lot of myths about psychoanalysis being focused on the past. And you were very pragmatic, and focused on what needed to happen now in these cases.

Dr. Kernberg: Well, they were very different cases. The first and the third case were psychotherapy cases. The second, I understood, was a beginning psychoanalytic case. And the difficulties of all three cases were very different,

Victor: Yes.

Dr. Kernberg: If you want me briefly to review them?

Victor: Sure.

Dr. Kernberg: Yeah. In the first case, I had a sense that there was a certain inhibition in the therapist in confronting the patient with the fact that—not wanting to have sex at all in the marital situation, and kind of conceding to have sex to humor the husband, without any pleasure or participation, was itself a source of irritation and limitation to the marriage.

And that the patient, who denied the importance of sex, needed to be confronted with the fact that she was denying the importance of one of the most fundamental issues for which couples get together, and implicitly utilizing this horrible past childhood to justify that attitude.

The therapist had difficulty to free herself from the idea that, with
such a horrible childhood, one could forgive the patient for not wanting anything more about sex. But then, after all, the patient got married and she wanted to have a better relation with the husband. So the patient was in a contradiction, part of which was the denial of the importance of sex. So I felt I should help the therapist to dare to be more affirmative in this regard with the patient. That was the main help I think I would give her.

**Victor:** You focused on that, and again, this, I think, dispelled some myths that some people have about some forms of psychoanalysis or psychoanalytic psychotherapy that you’ll be nondirective, where in this case, you were in fact urging the therapist to be very confrontative with the patient about this explicit matter. Whereas some therapists may just go on for years, and never bring this up, and as you say, side with—assume that, because the patient had this history of abuse, that that would be somehow assaultative to suggest that she should have a different type of sexual relationship with her husband.

**Dr. Kernberg:** Let me comment on that. I was directive in the sense of confronting the patient with a denial of the reality of the importance of sex.

**Victor:** Correct.

**Dr. Kernberg:** I’m not telling the patient what to do. I don’t tell the patient what to do. I’m not directive in telling them to go into a certain direction, but I try to confront them with the total reality in which they are.

**Victor:** I see.

**Dr. Kernberg:** In that regard, I’m very direct with patients. So it’s not directive in a sense of pushing them in a certain direction, but confronting them with a contradiction which she was living.

**Victor:** Right. So that’s an important distinction.

**Dr. Kernberg:** Yeah.

**Victor:** And a few words about the second case?

**Dr. Kernberg:** Yeah. About the second case, that was a little amusing because it was being seduced by traditional psychoanalytic theory to
go along with the defensive behavior of the patient, who was trying to 
avoid talking about his present troubles and difficulties by dragging in 
the history from the past, and at the same time, using his enmeshed 
relation with his family to avoid focusing on what the real difficulties 
are in his present life with his wife and work. And he managed to 
seduce, or better, to control the analyst in this regard, controlling the 
analyst by utilizing the seductive power of the interest in the past that 
the analyst naturally had.

So the analyst was seduced to do what he was most interested in, 
and in a way, not seeing clearly that he was being controlled with 
maintaining a curtain on top of the present issues and difficulties 
of the patient, to the extent that the analyst had not yet been able to 
gather the material to arrive at a diagnostic assessment to what the 
patient saw as problems in his present life and what the analyst saw as 
problems.

So in a way, he was getting stuck in the initial process of evaluation of 
the patient. And I tried to help him to see that. And in fact, there was 
a very clear parallel process going on, because while I was trying to do 
that, the analyst was tempted to repeat the patient’s behavior with me, 
and—without being aware of it—to seduce me to participating in the 
interest in the family dynamics of the patient’s past.

Victor: But you were not seduced.

Dr. Kernberg: I was not seduced, that’s right. And I tried to point 
out this issue, and the whole situation, as tactfully as I could to the 
analyst, who was also very open—very frank, very open, and I had a 
sense that it was possible to do that without any major problems.

Victor: So we’re talking about the case, and now you kind of transition 
to the consultation process where you were fairly confrontative with 
the therapist.

Dr. Kernberg: Yes, I’m very direct. I try to be respectful, but I’m very 
direct. And if—and sometimes, when I’m afraid I may be perceived as 
critical, I raise it, as I did with him. I asked him whether he felt that 
I’m being too critical.

Victor: So you kind of modeled the behavior of both being directive,
at the risk of being confrontative, but also gauging, in a sense, your alliance with him whether that was okay.

Dr. Kernberg: Right.

Victor: Yeah, and I thought you did a very nice job of that. You referred to the excessive focus on the past as psychoanalytic disease.

Dr. Kernberg: That’s right, because there is still the tendency, in psychoanalytic centers, to go into extended analysis of the past and neglect the present reality of the patient. Very often, I get presented patients where I have to raise the question, “What’s going on in love and sex, work and profession, social life and creativity? I mean, I’m not talking about esoteric issues. The complete issues of the…”

Victor: And people have the idea that the eminent Dr. Kernberg is going to want this full historical description, and that’s not at all the case.

Well, let’s move to the very interesting third case.

Dr. Kernberg: The third case, of course, is an extremely severe sexual inhibition and paraphilia or perversion with the combination of masochism and fetishism. And actually, I felt that the therapist was handling this case extremely well. She realized that the most urgent thing in that psychotherapy was to help the patient to decrease his sexual inhibition, the extreme sexual inhibition, and to help him find the capacity for some sexual gratification as a very necessary step in daring to approach a woman for an intimate relationship.

If he approached a woman while being totally closed to sex except making such impossible conditions that he might disrupt any starting relationship, he would be imprisoned in his present inhibition.

Victor: He would never be able to...

Dr. Kernberg: And I tried to help her to become freer. First of all, in obtaining some sexual gratification and accepting that he is functioning at a level of perversion, but to deal with that later on. But right now, he doesn’t even have the capacity to enjoy sex.

Victor: I must say, prior to the consultation, I talked with the therapist who was going to present to you, and she had some concern because,
as we saw in the consultation, she urged him and encouraged him in exploring his desires, and she was concerned that this would be seen by most therapists as wrong. And you actually fully supported her.

**Dr. Kernberg:** Yeah, I think she was doing the right kind of thing. First of all, deal with these obvious inhibitions at the behavioral level that can be dealt with, I think, by direct orientation. And you don’t need an analytic approach, although analytic approach can help by analyzing all the reasons for which he doesn’t dare to masturbate, doesn’t dare to touch his penis.

**Victor:** For understanding the psychoanalytic approach and you got to that a bit at the end, in terms of understanding the psychodynamics of his pathology. But in terms of intervention, what to do, you were advocating a stance that, again, is not what most people would think of as a psychoanalytic approach. But clearly the psychoanalytic approach is very broad and evolving.

**Dr. Kernberg:** The term “psychoanalytic approach” really lends itself to be misunderstood as referring to standard psychoanalysis. I think that psychoanalytic theory can be applied in standard psychoanalysis, in psychoanalytic psychotherapy, and in a supportive type of psychotherapy.

That patient has to begin with an indication for a supportive approach that will make him, hopefully, be able to function more freely in the sexual realm, at which point, a more analytic approach may deal with his deeper inhibitions. And after all, perversions are always a reflection of very severe sexual inhibition in which the sexual behavior is restricted to one area, that of the perversion, rather than having the broad flexibility that normal sexuality has. And it’s very important in that regard to look at it from the viewpoint of the interest of the patient, and not apply conventional thoughts about sexuality.

**Victor:** So stepping back and just, again, reviewing the consultation process in some of these cases. The first one, you were basically advocating a type of approach, or intervention at least, to raise—not to tell the patient what to do, but to confront her.

**Dr. Kernberg:** To confront her with the denial of the severe inhibition.
Victor: The second one, you’re more confronting him with the style of relating with the patient. And the third one, you were basically supporting the therapist to do what she was already doing.

Dr. Kernberg: Yes, I thought the third case was being handled with fewer difficulties, right now, than the other two.

Victor: And these are all important roles for the consultant or supervisor.

Dr. Kernberg: Yeah.

Victor: Alright. Well, thank you for stepping in and doing the consultations and taking the time to talk a little bit further about what you were doing. I think it’s going to be highly illuminating. It was to me, and I appreciate it.

Dr. Kernberg: You’re most welcome. It was a pleasure. It was a good experience. I think it reflected what I would do. After all, I was limited to 35 minutes per consultation, so I had to deal with the most important issue of the moment. In an extended process, of course, one can go—the consultation can be expanded in many ways. But in any case, it served perfectly, I think, to illustrate my general attitude and style, I trust.

Victor: All right. Well, thank you very much.

Dr. Kernberg: You’re welcome.

Victor: Take care.
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Special thanks to Dr. Kernberg for sharing his wisdom and knowledge.

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About the Contributors

VIDEO PARTICIPANTS

Otto F. Kernberg, MD is Director of the Personality Disorders Institute at The New York-Presbyterian Hospital, Westchester Division and Professor of Psychiatry at the Weill Cornell Medical College. He is also Training and Supervising Analyst of the Columbia University Center for Psychoanalytic Training and Research and is the Past-President of the International Psychoanalytic Association. He has received numerous awards for his excellence in Psychiatry and has authored or coauthored over twenty books.

Victor Yalom, PhD is the founder, president, and resident cartoonist of Psychotherapy.net. He also maintains a part-time psychotherapy practice in San Francisco and Mill Valley, CA. He has conducted workshops in existential-humanistic and group therapy in the U.S., Mexico, and China, and also leads ongoing consultation group for therapists.

MANUAL AUTHORS

Otto F. Kernberg, MD is Director of the Personality Disorders Institute at The New York-Presbyterian Hospital, Westchester Division and Professor of Psychiatry at the Weill Cornell Medical College. He is also Training and Supervising Analyst of the Columbia University Center for Psychoanalytic Training and Research and is the Past-President of the International Psychoanalytic Association. He has received numerous awards for his excellence in Psychiatry and has authored or coauthored over twenty books.

Ali Miller, MA, MFT, is a psychotherapist in private practice in San Francisco and Berkeley, CA. She works with individuals and couples and facilitates therapy groups for women. You can learn more about her practice at www.AliMillerMFT.com.
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Experts
Ellyn Bader
Judith Beck
Insoo Kim Berg
James Bugental
Albert Ellis
Kenneth Hardy
Sue Johnson
Jeffrey Kottler
Monica McGoldrick
Donald Meichenbaum
Scott Miller
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...and more

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