Instructor’s Manual
for
PSYCHOANALYTIC PSYCHOTHERAPY FOR PERSONALITY DISORDERS: AN INTERVIEW WITH OTTO KERNBERG, MD

with
OTTO KERNBERG, MD & TERRENCE OWENS, PHD

Manual by
Otto Kernberg, MD and Ali Miller, MFT

psychotherapy.net
The Instructor’s Manual accompanies the DVD Psychoanalytic Psychotherapy for Personality Disorders: An Interview with Otto Kernberg, MD (Institutional/Instructor’s Version). Video available at www.psychotherapy.net.

Copyright © 2010, Psychotherapy.net, LLC. All rights reserved.

Published by Psychotherapy.net
150 Shoreline Highway, Building A, Suite 1
Mill Valley, CA 94941
Email: contact@psychotherapy.net
Phone: (800) 577-4762 (US & Canada)/(415) 332-3232

Teaching and Training: Instructors, training directors and facilitators using the Instructor’s Manual for the DVD Psychoanalytic Psychotherapy for Personality Disorders: An Interview with Otto Kernberg, MD may reproduce parts of this manual in paper form for teaching and training purposes only. Otherwise, the text of this publication may not be reproduced, stored in a retrieval system, or transmitted in any form or by any means—electronic, mechanical, photocopying, recording or otherwise—without the prior written permission of the publisher, Psychotherapy.net. The DVD Psychoanalytic Psychotherapy for Personality Disorders: An Interview with Otto Kernberg, MD (Institutional/Instructor’s Version) is licensed for group training and teaching purposes. Broadcasting or transmission of this video via satellite, Internet, video conferencing, streaming, distance learning courses or other means is prohibited without the prior written permission of the publisher.

Miller, Ali, MFT & Otto Kernberg, MD
Instructor’s Manual for Psychoanalytic Psychotherapy for Personality Disorders: An Interview with Otto Kernberg, MD

Cover design by Julie Giles

Order Information and Continuing Education Credits:
For information on ordering and obtaining continuing education credits for this and other psychotherapy training videos, please visit us at www.psychotherapy.net or call 800-577-4762.
Instructor’s Manual for

PSYCHOANALYTIC PSYCHOTHERAPY FOR PERSONALITY DISORDERS: AN INTERVIEW WITH OTTO KERNBERG, MD

Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tips for Making the Best Use of the DVD</td>
<td>4</td>
</tr>
<tr>
<td>Transference Focused Psychotherapy</td>
<td>5</td>
</tr>
<tr>
<td>Reaction Paper Guide for Classrooms and Training</td>
<td>9</td>
</tr>
<tr>
<td>Related Websites, Videos and Further Readings</td>
<td>10</td>
</tr>
<tr>
<td>Discussion Questions</td>
<td>12</td>
</tr>
<tr>
<td>Role-Plays</td>
<td>15</td>
</tr>
<tr>
<td>Interview Transcript</td>
<td>18</td>
</tr>
<tr>
<td>Video Credits</td>
<td>48</td>
</tr>
<tr>
<td>Earn Continuing Education Credits for Watching Videos</td>
<td>49</td>
</tr>
<tr>
<td>About the Contributors</td>
<td>50</td>
</tr>
<tr>
<td>More Psychotherapy.net Videos</td>
<td>51</td>
</tr>
</tbody>
</table>
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. The Role-Plays section guides you through exercises you can assign to your students in the classroom or training session.

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
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 transference 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

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

• 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 model 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
Otto Kernberg: Live Case Consultation
Object Relations Therapy with Jill Savege Scharff
Object Relations Child Therapy with David Scharff
Time Limited Dynamic Psychotherapy with Hanna Levenson

RECOMMENDED READINGS


and psychotherapy of severe personality disorders. New Haven: Yale University Press.


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.

THEORETICAL FOUNDATIONS

1. Object Relations: What do you think of Object Relations theory as described by Dr. Kernberg? Does his focus on how clients relate to the significant people in their lives make sense to you? How does this fit with the way you conceptualize personality and psychopathology from an interpersonal and intrapsychic perspective?

ASSESSING AND DIAGNOSING PERSONALITY DISORDERS

2. Personality Disorder: Have you ever worked with anyone who you diagnosed with a personality disorder? If so, can you choose one client and describe what about their presentation led you to this diagnosis? What kinds of challenges and rewards did you face in your work with this patient?

3. Identity Diffusion: Kernberg defined identity diffusion as a “lack [of] integration of the concept of self and lack of integration of the concept of significant others because of severe splitting processes…” As you reflect on people you have worked with, does anyone come to mind who fits this description? Can you briefly describe how you worked with this person, including what approach you took and the challenges and rewards you faced?

4. Assessment: What stood out to you about the Structural Interview that Kernberg described? Were there some components of this that seemed especially useful? What do you think of the focus on present life and the intentional omission of questions about childhood? How do you assess for personality disorders in your work with patients? Can you see yourself utilizing Kernberg’s Structural Interview? Why or why not?
5. **Diagnosis:** Do you agree with Kernberg that “nowadays there has been such a deterioration of the diagnostic assessment because of lack of time, and because of the corruption of psychiatry by insurance agencies where everybody tries to place them into a diagnosis that’s reimbursable”? Do you agree with Kernberg that Major Depressive Disorder and Bipolar Disorder are over-diagnosed? Do you have any struggles related to diagnoses and your patients getting reimbursed? If so, how do you negotiate these struggles?

**NORMAL IDENTITY VS. IDENTITY DIFFUSION**

6. **Normal:** How did you react to Kernberg’s definition of normality? Did you recognize any of your patients in his definition? What did you think of his discussion of the distinction between “normal identity” and “identity diffusion”?

**UTILIZING TRANSFERENCE**

7. **Transference:** Different therapists define transference in different ways. What did you think of Kernberg’s definition: “The transference is the unconscious repetition of unresolved, dominant, pathogenic conflicts from the past”? How do you define transference? What are your thoughts about how Kernberg works with the transference? Do you work with the transference with your patients? How does your way of working with the transference differ from Kernberg’s?

8. **Neutrality:** What do you think of Kernberg’s style of “technical neutrality”? Do you take this approach with your patients? Why or why not? What do you think the advantages and disadvantages are of maintaining neutrality as a therapist? Can you give examples of ways you have not taken a neutral stance that has either been therapeutic or unhelpful?

**SETTING LIMITS**

9. **Limit setting:** What came up for you during Kernberg’s discussion about establishing rules of what patients can and cannot do? What did you think of the limits he sets with suicidal patients?
Do you set similar limits? What kind of rules, if any, have you established with patients? What factors do you consider in making these rules? What has been most challenging for you in setting rules or maintaining boundaries? Do you make yourself available to patients between sessions? Why or why not?

10. **Countertransference**: Kernberg described a case in which he got very angry with a patient and he couldn’t control his anger. What came up for you as he described his reaction to this patient? Have you ever been in a situation with a patient where you were so angry and you either couldn’t hide it or chose not to hide it? How did this impact the treatment? What are some ways you work with your own counter-transference?

**USING COLLEGIAL SUPPORT**

11. **Colleagues**: Kernberg stressed the importance of all therapists having a group of colleagues they can get support from. Do you have such a group of colleagues that you trust and with whom you discuss your clinical work?

12. **The Approach**: What are your overall thoughts about Kernberg’s approach to psychotherapy with people with personality disorders? What aspects of his approach can you see yourself incorporating into your work? Are there some components of this approach that seem incompatible with how you work? What in particular would you do differently from Kernberg?

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

STRUCTURAL INTERVIEWING ROLE-PLAY

After watching the interview with Dr. Otto Kernberg and reviewing the *Structured Interview for Personality Organization* (available at http://www.borderlinedisorders.com/mental-health-professionals-index.php), break participants into groups of two and have them role-play a psychiatric evaluation following Kernberg’s Structural Interviewing approach to assessing and diagnosing personality disorders. One person will start out as the therapist and the other person will be the patient, and then invite participants to switch roles. Invite patients to role-play someone with a narcissistic, borderline, or other personality disorder, based on their knowledge of these disorders and by Kernberg’s description of their behaviors during an interview. The patient’s responses should manifest one or more of the primitive defenses, such as: splitting, projective identification, primitive idealization, devaluation, and/or omnipotent control.

The therapist should focus less on actually diagnosing the patient and more on getting a feel for asking the questions Kernberg asks.

Invite therapists to practice some of the techniques of the Structural Interview that Kernberg discussed in the video, such as:

1) **Symptom Evaluation:**
   a) Ask patients about all of their symptoms, encouraging patients to reveal all the details of their symptomatology.
   b) Ask patients, “If you didn’t have any of all those symptoms, would you be perfectly alright?” Keep eliciting problems from patients until they can respond to the previous questions with, “Well, if I didn’t have anything of all that, yes, I would be alright.”

2) **Present Personality Evaluation:** Ask patients about their present life, inviting patients to go into sufficient detail so that therapists have a sense of knowing the patients and how they function in these three major areas:
a) Love and sex: Has the patient ever been in love? Is the patient in love now? Does the patient have a satisfactory sexual relationship?

b) Work and profession: Is the patient’s work commensurate with background training, abilities and intelligence? What are the patient’s professional aspirations? How does the patient relate with colleagues, superiors, and subordinates?

c) Social life and creativity: What are the patient’s current relationships like with friends, family, parents, siblings? What are the patient’s interests? Any creative pursuits?

3) Identity:

a) Ask patients to describe two of the most important people in their life, asking, “What’s unique about this person?” Therapists should be listening for whether or not, based on the patient’s description, they are able to get an image of that person, or whether the description is too chaotic or superficial to get a sense of who this person is.

b) Then ask patients to describe themselves, asking, “Now, could you describe yourself so I get an image of you? What’s unique about you? What makes you different from everybody else? What do you see as essential?”

After the role-plays, have the pairs come together to discuss their experiences. First, have the patients talk about what it was like to role-play someone with a personality disorder, and how they felt about the therapist’s questions. Did they feel safe with the therapist? Did they feel heard and understood? Were they able to sufficiently embody the patient so that they felt they obtained experiential insight about what it is like to have a personality disorder? Then have the therapists talk about their experiences; how did it feel to conduct this type of structured interview? What did they find useful or enlightening about these questions in terms of gaining a fuller understanding of personality disorders? What was most difficult about conducting this structured interview? Did they notice any countertransference reactions? Finally, open up a general discussion of the strengths
and the challenges in applying Kernberg’s approach to assessing personality disorders.

An alternative is to do this role-play in front of the whole group with one therapist and one patient; the entire group can observe, acting as the advising team to the therapist. Before the end of the session, have the therapist take a break, get feedback from the observation team, and bring it back into the interview with the patient. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about using Kernberg’s approach to assessing personality disorders.
Complete Transcript of 
Psychoanalytic Psychotherapy for Personality Disorders: 
An Interview with Otto Kernberg, MD

THEORETICAL FOUNDATIONS

Terrence Owens: Hello. My name is Dr. Terrence Owens. I’m here with the eminent psychoanalyst, Dr. Otto Kernberg. Dr. Kernberg has contributed to the field of psychoanalysis, psychotherapy and psychoanalytic research for a number of decades. He’s on the faculty at Cornell, works at New York Presbyterian Hospital. Welcome, Dr. Kernberg.

Otto Kernberg: Good morning.

Owens: Dr. Kernberg, Steven Mitchell wrote in his book, Freud and Beyond, that, “For Kernberg, the centerpiece of personality is the development of a level of internal object relations the patient has reached.” Is that a fair characterization of your thinking and your work?

Kernberg: Well, it’s somewhat simplified. It deals with central issues—the development of psychic apparatus in the context of the internalization of object relations, and the structural development of those internalized objects relations. It’s on that basis that I reached overall classification of personality disorders that includes dimension of severity that’s determined by the level of organization of internalized object relations.

A higher level of less severe personality disorders and normality, on the one hand, is characterized by normal identity, and severe level of personality disorder—what we have called “borderline personality organization” in contrast to neurotic personality organization at the higher level—is characterized by the syndrome of identity diffusion, which consists of a lack integration of the concept of self and lack of integration of the concept of significant others because of severe
splitting processes that separate, in an absolute way, a positive or rewarding libidinal internalized object relations from negative, aversive, aggressively infiltrated internalized object relations.

So the level of integration of object relations, in other words, of self-organization and organization of representation of significant others, determines, more than anything else, levels of severity of the personality disorder, and can be assessed relatively easily in initial diagnostic assessment, and determines both treatment approach and prognosis.

**Owens:** I’d be interested to get at how you make that assessment of these internal object relations. Also not wanting to assume too much knowledge on the part of the people that will be watching this, I’m wondering if it would be helpful to define some of the fundamental concepts that you just referred to there, such as object relationships. Something as simple as that would probably be useful to hear your thoughts about.

**Kernberg:** The term “object relationships” refers to the significant relation between self and others. It should actually be called Other Relationships theory. But the term “object” has been since time immemorial within the psychoanalytic literature, so it has been kept. But objects are, in this regard, not material objects but human—other people.

**Owens:** Human relations.

**Kernberg:** So that we are talking about human relations. Which means relations between self and significant others. I’m always adding the word “significant” because, of course, we relate to the milkman, and the postman, but, that’s not very relevant to the deeper processes of our psychic functioning in contrast to the relation to the primary objects—to the parents—from birth on, throughout the childhood and adolescence. It’s a fundamental function in the organization of psychic life.

Object relations theory is a development within psychoanalysis that, in essence, has transformed the classical view of unconscious intrapsychic conflict between drives and defenses that was postulated
by Freud.

Libido and thanatos, or love and aggression, is basic drives that, in the most primitive forms—wishes desires, expectations—run into conflict with the demands and prohibitions of reality. Those demands and prohibitions are internalized. A set of defense mechanisms is set up within the mind that keeps control — suppress, repress in the sense of unconscious suppression—those drives. And when that process is incomplete, insufficient, breaks down, symptoms emerge, so that symptoms were seen as compromise formations between drive derivatives and defenses. Classical psychoanalysis.

The Psychoanalytic Object Relations theory has modified that by pointing to the fact that both drives and defenses are really represented by internalized object relations that acquire a drive related function, or a defensive function, so that the conflict is between contradictory internalized object relations. And that when we talk about libidinal drives—we talk about libidinal in the broad sense—dependent sexual wishes represented by an internalized relation between a self-representation and an object-representation framed by a certain libidinal desire, and the interaction that occurs under the impact of the desire as opposed to a defense. For example, prohibition represented in turn by a relationship between the self-representation and object-representation within the frame of an affect directed against that impulsive desire.

Owens: It’s not as if drives and defenses have been thrown out. It just incorporates the object relationships.

Kernberg: Yes. They have not been thrown out, but they have been translated into an Object Relations perspective.

Owens: The actual influence of the objects—the actual mother, the actual father—not say, in Freud’s Oedipus where it’s almost… these drives come into contrast with a forbidding father, or a desired mother. It’s as if the personality of that parent matters little. But in Object Relations, it seems the personality—the ego structure of the parent—matters a great deal. Is that fair to say?

Kernberg: I think that’s not quite fair to Freud. He thought that
the reality of the parents mattered significantly. Even Melanie Klein thought that. But what is internalized is usually not the direct replica of the significant others. But the more intense, the more primitive the drive involved, the more what is internalized is a distorted image under the influence of the projection of internal fantasies. So when we talk about the internalized reality from the past, we are not talking about photographic reproduction.

Owens: It’s not veridical reality. It’s not actual reality.

Kernberg: It is an experienced reality that I think Melanie Klein defined very elegantly, that is constituted by realistic elements of the parents, by fantastic elements of the parents, and defenses directed against both. So it’s a composite structure. What remains in our unconscious is not actual reality, but that composite structure. And of course, the real behavior and attitude of the parents is extremely important, although it’s registered and internalized in ways that are changed, distorted in terms of internal needs.

There’s one thing I would like to add, and that’s another fundamental aspect of Object Relations theory. I have used the term “drives” rather loosely, but the nature of the drives is under discussion. Under the influence of Object Relations theory, there has been questioning of whether the concept of drives, as formulated by Freud, is really valid or not. I won’t go into all the controversies, but I’ll be glad, if you wish, to give you my views.

Owens: I’d very much like to hear your views on that, yes.

Kernberg: As long as I make it clear that it’s a personal view, although I think it is a view that’s gaining acceptance. Some leading Psychoanalytic theoreticians have moved into the same direction.

Owens: I think you should give us your personal views, yes.

Kernberg: Joseph Sandler, in Great Britain, Reine Krause in Germany, Serge Lebovici in France I think that there is a direction that goes that way. Anyhow, I’ll define where I stand. It seems to me that there is solid evidence that the primary motivators of human behavior are affects. Freud recognized that there was no neurobiology on which he could base his theory of drives, and that it was a kind of
metapsychology or mythology. He was quite clear, although he used the concept so completely that the generations of analysts just never questioned it. But it’s a fact that he could not base it in neurobiology, because neurobiology of his time was in its infancy.

On the basis of today’s knowledge, I think we may affirm that basic motivators are affects. And affects are inborn structures, complex inborn structures that are constituted by subjective experience—facial expression and dissociated psychomotor movement that have communicative functions, neurovegetative discharge, cognitive framing in terms of assessment of the immediate perceived situation in which such an affect emerges. Complicated packages that contain both emotional and cognitive elements.

And in my view, it is the activation of affects in the context of infant-mother — infant primary object relations—that determines the highly focused attention on the interaction—the perception of the interaction—between self and other within the frame of that affective experience. And the internalization is affective memory of that experience. Dyadic internalization of a representation of self, the representation of the object related to the self, within the frame of that particular affect. I see these as the building blocks of the mind. The internalized relations with the same affect tend to get integrated. And I see the drive of aggression as the hierarchically supra-ordinate integration of all negative affectively determined experiences.

Owens: Can you say why you placed that emphasis on aggression as the superordinate?

Kernberg: As one of the superordinates. And the other one is the libido, as the superordinate integration of all positive affectively determined internalized object relations: all gratifying, sensually stimulating, euphoric, surprising moments that come together as a major motivation. Basically, libidinal motivation toward affiliation, closeness dependency, eroticism, sexuality, is opposed to escape, attack, hostility—but also autonomy, self-affirmation. And the basic conflicts are between these drives that are composite structures. And of course, they influence each other. Aggression becomes pleasurable because it requires a libidinal component, and libido acquires
aggressive components that intensify pleasure. All erotic pleasure has an element of aggression in it in small doses. So they are mutual recruitments. And what happens in the case of pathologies, there is such a predominance of aggression in recruitment of libidinal desire—pleasure in its service—that the entire structure of the personality gets distorted. So when I talk about drive-determined behavior and defenses against it, concretely, it’s always represented by a relation between negative and positive affect-invested internalized object relations. So that completes the picture of what I see as a model of Object Relations theory.

**ASSESSING AND DIAGNOSING PERSONALITY DISORDERS**

**Owens:** I’d be interested to hear your thinking about borderline personality organization. You referred to it earlier in our talk today and have written about it extensively. Again, you’ve covered parts of it in what you’ve already said here today, but I’d like to hear your description of it.

**Dr. Kernberg:** For practical purposes what we are talking about—my Personality Disorders Institute at Cornell, which I’m the director, and where we’re carrying out all the research on the psychopathology and treatment of borderline conditions, borderline personality organization refers to the group of severe personality disorders that is categorized by the presence of identity diffusion—the predominance of primitive defensive operations centering around splitting rather than higher-level defensive operations centering around repression—and, by permanence of reality testing, but a certain weakening of it, in the sense of a more subtle tact in social life and interpersonal interaction that tends to get lost. So there are diffuse, subtle but consistent problems, in fine-tuned relations with significant others, but within a context of maintained reality testing, in contrast to psychosis. Predominance of primitive defensive operations that tend to distort interpersonal relations, and above all identity diffusion that clearly differentiates them from the milder personality disorders that we call neurotic personality organization.

And as I mentioned before, it is possible to assess that in diagnostic interviews constructed specifically to make that diagnostic
assessment, in the course of which you can, at the same time,
define the specific constellation of pathological character traits that
differentiate the different personality disorders from each other.

**Owens**: Can you describe some elements in that assessment, of what it
is that you focus on?

**Kernberg**: Yeah. We have developed a method that’s called Structural
Interviewing. It’s not a structured interview, but structural because
it tends to diagnose intrapsychic structures, particularly identity
defensive operations, reality testing, et cetera. The interview starts
out asking the patient about all his symptoms. We try to go very
completely in a full symptomatology, through all these details,
make differential diagnosis of symptoms, to make sure that we
have everything registered before the treatment starts. So it looks,
at the first moment, as a very detailed, almost obsessive, psychiatric
interview.

And in the middle of this we ask the patient, “If you didn’t have any
of all those symptoms, will you be perfectly all right?” And we go to
a point where the patient says, “Well, if I didn’t have anything of all
that, yes, I would be all right.” Or the patient says, “Well, who doesn’t
have some kind of a problem?” We ask the patients first, “Are you
saying that if you didn’t have anything of what you’ve told me so far
you would be like everybody else?” “Yeah, of course.” And then we go
on and ask the patient about his present personality. We don’t go into
infancy—sharp, subtle difference from traditional psychoanalytic
interview.

**Owens**: Meaning you don’t ask much about the parents at this point?

**Kernberg**: No. We ask about the present life. And we have three
major areas in mind: love and sex, work and profession, social life
and creativity. And we go into it in great detail, to the point where the
interviewer has a sense, “I know that person, how he or she functions
now, in all aspects of his life.”

And we ask about the person, his relation as a couple: has he ever been
in love, is he in love now, whether that’s a good relationship, whether
that person has a satisfactory sexual relationship. And whenever a
problem pops up, we ask, “What’s the issue?” “What’s the problem?”
Same with work: effectively working, commensurate with background training, aspirations, interests, relations with colleagues, superiors, subordinates.

We ask about social life—and within social life, intimate relations: friends, family, family of origin, parents—in terms of the present relation with them. And then, what the person does, or is interested in, or aspires to—other than what he does for a living, or within what the person does for a living—what kind of additional aspirations that reflect an element of creativity. On that basis, we already are practically able to make the diagnosis of the personality disorder in terms of conflicts, rigidities that get uncovered in what the patient tells us, and how the patient tells it to us, of course.

But we are particularly attentive to the main person in the patient’s present life. And that gets us to the issue of identity, because after having completed symptom evaluation, present personality evaluation, we ask the person, “I would like you now to describe to me the two or three most important people. Can you tell me about your wife? Can you describe her in a few minutes, or get a live picture of her so I get a feeling for what makes her different from anybody else? What’s unique about her?”

Owens: Listening for what kind of information, though? Let’s say they’re speaking of their spouse. What are the differentiations you’re listening to?

Kernberg: I’m coming to that. So we ask them to make such description about two or three persons. And what we are after is the extent to which the interviewer is able to get an image of a defined person from that description, or the extent to which that is impossible because the description is just so chaotic, or is so cliché and superficial, that you get no sense. That’s the most difficult part of the interview. That needs training.

And the way we train our therapists is, on the one hand, we let them see many disturbed patients, and invite them, urge them, to do this same test with their friends and family, because we assume that most of their friends and family are not borderline patients, severe
borderline patients. And that’s a learning process that permits them, in a few months, to become experts at this—whether there is a description in depth, and the different persons the patient describes different from each other, or whether there is such a flatness that you can’t get any image.

After we do that, and only after we do that—which is a training for the patient—we ask him, “Now, could you describe yourself so I get an image of you? What’s unique about you? What makes you different from everybody else? What do you see as essential?” It’s not easy to do that. It requires a process of thinking. It requires an intense effort both to describe others and self. But in that context, you can test the difference between normal identity, capacity for an integrated view of significant others and of self, and identity diffusion. So that gives us the key response to the question about identity.

And of course, in the process of everything that we’ve done so far, there is—whenever we don’t understand something, when something seems contradictory, conflictual, we tell the patient, “I don’t understand that. That sounds like a contradiction. Can you clarify that for me?” We are really testing the defensive operations.

With patients having normal identity, you get a normal interaction that tells you nothing else except the concrete content. But with patients having severe personality disorder, the primitive defensive operations start, manifest: splitting operation, projective identification, primitive idealization, devaluation, omnipotent control. That varies from case to case. We don’t hang the diagnosis on that, but it enriches the differential diagnosis.

And then and the end, we do something that is extremely important and very simple to learn: the differentiation of a personality disorder from psychosis. Whenever patients seem to get a kind of a strange, flaky, cuckoo aspect, something is wrong. Either their affect, or their thought, or their behavior in the interaction with us is strange. At that point in the interview, not before that, we may tell the patient, “You know, as we’ve been talking, I have noticed” such-and-such in the patient’s affect for whatever it is that seemed to us the strangest. “I’ve noticed” such-and-such. And we describe it in a tactful but clear, open
way. “And that seems strange to me. Can you see that?”

Patients who have good reality testing are able to empathize with ordinary social criteria of reality that you represent, understand what you’re saying, and give you an explanation that makes what seems strange more understandable. That completes the diagnosis. Patients who have an atypical psychotic illness are very threatened by that. They tend to get disorganized. So that indicates loss of reality testing.

Owens: Become paranoid under that kind of questioning, is that…

Kernberg: They may get paranoid or totally confused, but particularly, as you point out, paranoid—severely paranoid. So it opens the possibility of an undiagnosed atypical psychotic reaction, and we investigate that further. Of course, if at any point the patient looks either organic or psychotic, we shift into a traditional psychiatric interview. This is a specific interview geared to the diagnosis of severe personality disorders. We have tested that, researched it. It’s clinically extremely helpful. It is of no use as a research instrument.

Owens: It’s not? Huh.

Kernberg: It’s too—called “vague diffused” because it’s so subtle. So we transformed it into a structured interview: a STIPO, Structured Interview for Personality Organization. The STIPO has empirical evidence and is a good instrument for assessment of personality organization. And that’s what we’re using for research purposes. I’m saying this to make clear that this is not a research instrument.

Owens: It’s a diagnostic instrument.

Kernberg: It’s not a research, but it’s an excellent diagnostic interview. I do it in my practice, I get difficult cases for consultation all the time. Such an interview takes between 45 minutes and an hour and half. I always give patients first a double session—hour and half. Most difficult cases may take two or three interviews, but not more. It’s, unfortunately, much more precise and accurate than most of the diagnoses with which the patient come to the hospital, because nowadays there has been such a deterioration of the diagnostic assessment because of lack of time, and because of the corruption of psychiatry by insurance agencies so everybody tries to place them into
a diagnosis that’s reimbursable. Fifty percent of patients who come with a diagnosis of Major Depression don’t have it; they have a chronic dysthymic reaction, or characterological depression. Bipolar illness is vastly overdiagnosed. ADHD starting in, during adult age. I think you’re a child psychiatrist, so you know what I’m talking about.

Owens: I sure do.

Kernberg: So we are able then, to rapidly correct forced diagnoses that, unfortunately, are more frequent now than ten years back.

Owens: This might be a side point, but I have had a concern that as these false diagnoses are applied—ADHD, bipolar disorder, et cetera—it actually contributes to identity diffusion. That it’s an introduction of yet another way of thinking of the self that’s incorrect, or confuses the individual. They begin to see themselves through a lens of psychopathology. “I behave this way because I have a bipolar disorder,” for example.

NORMAL IDENTITY VS. IDENTITY DIFFUSION

Owens: So in light of this diagnostic interview, how would you make the determination that a patient has a normal personality organization versus one that would be identified as a diffusion of personality?

Kernberg: The decision is whether the person has normal identity or identity integration, or identity diffusion, one of the two. Normal identity—or normal identity integration, it’s the same thing—indicates either a personality disorder at a higher level—less severe—or normality: maybe the patient has no illness at all. So in either case, identity would be normal. And of course, “normals” would be differentiated from personality disorders in that there’s smooth and effective functioning in all major areas that I mentioned. The patient is effective, flexible, adaptive, satisfied, independent, autonomous, yet able to depend also, gratifying his internal needs without excessive conflicts with environment, has independent interests, an intimate relationship, love relationship with a good sexual relationship. Everything is fine.

And we get such patients, because sometimes parents who are either psychologists, or psychiatrists, or psychoanalysts, they have rebellious
adolescent children. They think, “Oh, my kid has a borderline problem.” Drag them to a psychiatrist who then has to tell them, “This is a perfectly normal adolescent. You just have to adjust your relationships.” But let’s assume that this is a person with a significant personality disorder. By the way, I just defined normality.

Owens: Yes.

Kernberg: And then, with this investigation of the description of significant others and self, we can make the distinction. The person who has a normal identity is able to describe other people in a differentiated way in-depth. In a few minutes they convey some essential aspects that permit the interviewer to get a feeling for that other person in the patient’s life, and does the same regarding himself. The patient describes himself in a few essential characteristics that give the interviewer the feeling of how the patient perceives himself. And they are harmonious with what he has told about his life and what the interviewer sees in the interview.

So if there is an integrated view of self, and an integrated view of significant others: normal identity. If there is a lack of an integrated view of self and lack of integrated view of significant others: identity diffusion, severe personality disorder, or borderline personality organization.

Owens: Could you give some examples—real-life examples—of what some of the things you just described might look like?

Kernberg: One of our borderline patients described her mother in completely contradictory terms. “Oh, she’s very concerned, and very loving, and always available, and extremely critical, and goes through my letters, and you don’t know when she’s going to jump next.”

Owens: Now, that’s an example of what you would describe as splitting, right?

Kernberg: Yes. It’s a mechanism of splitting, but at the same time, it is incapacity to convey a realistic picture. Now, a person may say, “My mother is a completely chaotic person.” That’s very different because the patient has an awareness something is wrong. But if the patient conveys that without any critical attitude simply because there’s an
incapacity...That same patient has several brothers and sisters. So we asked her to describe the two that seemed to be closest. And she said, “Oh, my brother, he defends me. I can count on him to defend me.”

So we said, “Well, what kind of person is he?” Well, as I told you. You know, I can count on him. And that’s—I can’t count on most of the others.”

“What about your sister?”

“Well, she precisely, one who is always after me, takes away my stuff.”

“Can you tell us about her other than what she’s doing to you?”

“Well, she does all right in school. I don’t know what else I could say.”

And in asking the patient to describe herself, she said, “Well, that depends with whom I am. I’m different. And there’s always something underneath,” she said. She said, “Sometimes I feel like an onion, you know?” “What do you mean?” “You can peel it, and there’s a deeper wave, the real onion comes out, and then you continue peeling and there’s another onion, and at the end you have nothing.” And the patient looked kind of slightly ironic and sad at the same time.

Now, the second example: a narcissistic personality. He looked much better on the surface, and described himself: “I think I’m a rather unusual person, extremely intelligent. I have sensitivity that very few people have. And people are not aware of it, can’t even appreciate it, but I’ll—I’ll live with that. I always try to go to the depth of things. Most of the people live on the surface of themselves.” That was the description of himself: an integrated grandiose view.

And he was a man who was sexually promiscuous. So we asked him to describe...he was involved with three women. So we asked him, “Can you describe them?” And he started to describe them, and the three were exactly the same. And the description, I don’t think it’s worthwhile to repeat that, but they were. So our interviewer said, “Are they really exactly the same? Or...” And he said, “What do you mean? They’re very different.”

“Well, my impression in what you said...”

“You misunderstood that.”
“Well can you tell us, in what way are they different from each other?”
“Would have to show you — want me to bring you photographs?”

So here you have an apparent integration but at a grandiose level, and on the other hand, even more dramatic incapacity to describe others, so that identity diffusion shows a different way with different characterological constellation, but always has in common the difficulty of describing a realistic assessment of others so that a third person can recreate the person, and the discrepancy between either a chaotic or a grandiose self-description and the total reality that one perceives.

**Owens**: How important is the etiological distinction there? You talk about borderline personality organization as a substrate, and out of that can come borderline personality disorder, or narcissistic personality disorder.

**Kernberg**: There are different constellations, so that we have both quantitative criteria—severity of illness. We also have other quantitative criteria: degree of introversion versus extroversion, which is a temperamental dimension, and severity of aggression. So they are severity of aggression, severity of pathology of internalized value system or superego functioning. So there are quantitative differences among personality disorders, and qualitative, categorical. Our description of personality disorders includes both categorical and dimensional criteria.

**Owens**: Does that then orient your treatment?

**Kernberg**: We have developed psychoanalytic psychotherapy for all personality disorders. But there are different specific techniques that have to be developed—for example, in the case of narcissistic personalities who have a very specific constellation of defensive operations. And that makes the treatment more difficult, the prognosis more serious. We also use our assessment for prognostic assessment. There are some general negative prognostic features that create alarm.

**Owens**: I believe you’ve said that some people just can’t be effectively treated. Is that true?

**Kernberg**: The antisocial personality disorder in the strict sense has a
prognosis zero for treatment, for psychotherapeutic treatment, I think for all psychotherapy—that these patients can’t be treated—when the diagnosis of antisocial personality is made accurately. The DSM classification is rather poor in that specific differentiation. And the overall prognosis depends upon two major features. One is linked to the personality, namely, severity of antisocial features. The more severe the antisocial tendencies, the worse the prognosis.

The other is linked to the adaptation of the patient, including his illness, to external reality. I’m talking about secondary gain. The more severe the secondary gain, the worse the prognosis. And that is a major obstacle to treatment.

Secondary gain refers to the fact that the very illness provides the patient with additional support of symbolic, or financial, or any other type that tends to consolidate it or operates against motivation for change. Most importantly, financial support by wealthy family of ill patients who use the illness for a parasitic lifestyle or social support system that has created kind of a legion of chronic, parasitic patients who supposedly can’t work. Should really be able to work, but the social system protects them, and that makes the prognosis very negative.

**UTILIZING TRANSFERENCE**

**Owens:** Well, you’ve defined many of your concepts well in talking about personality organizations and personality psychopathology. I’d like to move us towards psychic change, and your ideas about treatment, about transference, and how is it that one is able to alter these psychic mechanisms within people? So I guess the place to start would be to hear your thinking about transference, how you define it. It’s defined so many different ways, but I’d be interested to hear your thinking about that.

**Kernberg:** Maybe I can start out saying that we have developed a psychoanalytic psychotherapy for severe personality disorders, for borderline personality organization. And I fear to say that it is no longer the only psychoanalytic psychotherapy for these patients. Fonagy in London has developed mentalization-based psychotherapy, which deals with the same issues, but in my view, really focuses on
the early stages of the treatment that practically coincides with what we are doing, with somewhat different terminology. And we have developed detailed, manualized treatment that is perhaps the only detailed, manualized, strictly psychoanalytic treatment for these conditions. Not standard psychoanalysis and modified treatment for severe personality disorders, but strictly analytic in the sense that it uses an interpretive approach. It doesn’t use supportive, ego-strengthening techniques. Although we expect it to have a supportive effect, we’re not using supportive techniques. And that treatment has a general strategy—technical application of psychoanalytic instruments and tactics. I’m saying this because you asked me, “What about transference?” And indeed, transference analysis is the center of the treatment. And before defining transference, I would like to say how it fits into the overall treatment that I’ve mentioned.

The strategies—the overall objectives—are to correct the identity diffusion. And by the way, we call it identity diffusion because we take the term from Erikson. It could—more elegant would be to say “non-integrated identity syndrome.”

Owens: Erik Erikson is what you’re referring to?

Kernberg: Oh, I’m referring to Erik Erikson, yeah, right. I think that that’s important to clarify. Erik Erikson really did a very important contribution that sometimes is not fully appreciated nowadays. Of course, we have developed the concept further, are also very much under the influence of other authors: Edith Jacobson, et cetera.

Anyhow, we try to integrate that split or dissociated identity. That’s the overall objective. And we try to do that by permitting the activation in the treatment situation of the conflictually determined, unconscious, internalized object relations in the relationship with the therapist. And that’s the transference. The transference is the unconscious repetition of unresolved, dominant, pathogenic conflicts from the past. And they reactivate, in the relationship between patient and therapist, conflictual situations from the past. Not in the direct, photographic reproduction of the past, but as I mentioned earlier, a combination of realistic and fantastic enactment, and defenses against both. Transference, then, is a very complex structure.
The activation of these mutually dissociated relationships in the transference permits us to diagnose them, clarify them, confront them, interpret their function in the here-and-now, and interpretively connect them. I’ll have to explain how we do this a little later.

Owens: Okay. It sounds like your emphasis is on the distortions that are in the relationship.

Kernberg: Yes. Obviously, in a certain sense, everybody transfers all the time in the sense that the past influences the present. But we correct, mutually, our potential distortions. So we keep normal in voluntary social intercourse. In the treatment situation, if the therapist—the same as the analyst—does not respond with the usual social cues to the activation of certain distorted or distorting behaviors on the part of the patient, those transference patterns get much more intense, observable and workable. So we try to facilitate the activation of the transference dispositions of the patient in order to clarify, then analyze them, and resolve them.

Owens: How does one facilitate transference dispositions like the ones you just described?

Kernberg: We don’t—we facilitate their activation by not tuning them down by ordinary social responses. The patient comes in and he may say, “You looked at me rather strictly. I wonder whether you’re criticizing me because of what I told you in the last session.” In an ordinary social interaction, the therapist would say, “Far as I am aware, I wasn’t looking at you critically, far as I am aware. And I certainly don’t feel critical because of what you say. No, you’re wrong.”

Well, the therapist doesn’t do that, of course. But the therapist tells the patient, “Tell me more about that.” In other words, the therapist maintains an attitude of technical neutrality. Technical neutrality means a concerned objectivity: not reassuring, not normalizing, but trying to clarify what is going on in the patient’s internal mind. Clarifying what is going on in the patient’s mind, observing the patient’s nonverbal behavior, and tactfully pointing to the patient what he observes in the patient’s nonverbal behavior, listening to his own emotional reaction to the patient as instrument to assess what’s going on in the interaction. And combining what the patient says, how
he behaves, and how the therapist feels into a total analysis about the dominant transference relationship that is now being activated.

So the therapist focuses on the transference, maintains technical neutrality, uses countertransference responses, and interprets to the patient what is going on. These are the treatment techniques: interpretation, transference analysis, technical neutrality, and countertransference analysis.

**MAKING INTERPRETATIONS**

**Kernberg:** And when we talk about interpretation, it has phases. First, to clarify what the patient—what’s going on in the patient. Not telling the patient what’s going on, but asking the patient what he feels. Whenever the therapist doesn’t understand something, he asks, so to get as far as he can in the patient’s conscious experience.

And of course, the patient receives the instructions at the beginning of the treatment to carry out free association, to say whatever comes to his mind without prepared agendas, without trying to control or suppress anything. And the patient is told that this is a process that he has to learn gradually, that the therapist will help him to learn this, but that’s his task. And that the therapist’s task is to listen attentively to the patient. And every time the therapist has something to contribute to the understanding of the patient of himself, he’ll do it. So the therapist defines the task for the patient, defines his own task, and with this, defines the nature of the relationship that is the “normal one” in the sense of the norm for therapeutic work together.

As Loewald pointed out many years ago, this “normal” relation, of course, implies already a very specific emotional meaning: somebody who needs help, who has a minimum sense of trust of somebody else whom he thinks has the knowledge, the good will, the good intention to help without being omniscient and omnipotent, and somebody who is interested in the patient, honestly interested, has knowledge, has the interest, is aware of his own limitations, but within that, willing and able to help.

And this normal relationship then gets distorted from moment one by the emergence of the patient’s transference disposition—the unconsciously unresolved conflict in the form of internalized object
relations that are, most importantly, frozen into the patient’s habitual character traits or behavior patterns, that are now activated in the treatment situation, so that what we would call character defenses become transference resistances.

And by the way, when I say resistances, I mean the emergence of defenses, defensive operation in the treatment situation, not the patient’s opposing or behaving badly. And it is stupid to tell a patient, “You’re resisting,” as you see sometimes in caricatured version of analysis. Those behaviors are extremely interesting because they show the activation of the characterological pattern.

For example, a patient appears extremely friendly and does everything to conform with whatever the therapist wants, and looks for cues as if he were all the time kind of careful not to step on the therapist’s toes. And the therapist has a sense while the patient is free-associating, and looking at him from time to time. By the way, we see patients face to face to highlight effective communication, and even highlight the experience of countertransference.

So the therapist may, at this certain point, first clarify what the patient is thinking, and clarify that the patient is kind of worried all the time of doing the right thing, tactfully confront the patient with his having a certain kind of ingratiating attitude, as they’re trying to behave as he thinks would be most pleasurable, comfortable for the therapist—to then interpret, in other words, from clarification and confrontation lead to an interpretation of the unconscious meaning in the here-and-now.

For example, that perhaps the patient needs to maintain the relationship all the time, extremely friendly, out of a fear that if that breaks down, he might be severely criticized. In other words, the therapist interprets defensive—a defense—an object relation which is a defense against the underlying one, threatening one, of the patient as a victim of an extremely critical authority.

So interpretation has phases: clarification, confrontation, interpretation of unconscious meaning in the here-and-now. And eventually, once the patient is really emotionally discovering unconscious meanings in the here-and-now, the linkage between that
and unconscious experiences from the past.

We never link conscious present with conscious past. We link unconscious present with potential unconscious past. And that takes a long time with severe borderline patients. So there are a number of differences with psychoanalysis in what I’ve said. I don’t know whether I should go into that.

Owens: Let me just clarify something a little bit. I’d like to say something about what you just said in terms of how you work with your interpretations. It’s clear that you’re not making historical reconstructions. You’re not saying, “You perceive me as critical because of your hypercritical father.”

You don’t speak in those terms. Rather, you help cultivate their feeling of criticism in the moment, and that it’s happening right now. And that is what the emphasis is on, is what’s occurring between the two of you. Is that fair?

Kernberg: Yes, unconscious—the present unconscious in Sandler’s term.

Owens: Now, do you bring in, say, the other side of that a bit? Say, in that example, that for someone who is being ingratiating, that one way of thinking about that is they perceive the other as someone emotionally fragile? That they have to be careful with them? They have to remain aligned with them? Would that be an element of your interpretation?

Kernberg: Well, if the patient conveyed the sense that the therapist is extremely frail, then of course, I would interpret that. In the example that I gave you, clearly seemed that the therapist was very powerful. The patient better tread carefully. If the patient treats the therapist, “Poor little therapist. I have to treat him carefully because he’s so frail.” I would interpret that. “It sounds as if you have to treat me very carefully, because if not, I’ll fall apart.”

It depends what is being activated. Usually, with borderline patients, the transference has become rapidly, predominantly aggressive. For example, one of our patients behaved not only kind of cautiously as though they’ve been cornered, but practically withdrew into a
corner and conveyed the impression of a prisoner being interrogated by a sadistic prison guard, and experienced the intervention of the therapist as sharp, horrible, devaluing attacks. He was trying to protect himself.

Now, what’s typical for a borderline patient is that these activations with the transference operate within generalized splitting of object relation, so that this object relation floats, so to speak, in the middle of contradictory ones. And that means that by processes of projective identification—another primitive mechanism—the patient rapidly exchanges roles with the therapist. And the patient, who is frightened to death because the therapist seemed like a dragon, ten minutes later they become extremely aggressive. “What were you telling me? How can you say such a thing to me? You’re totally wrong. I mean, that’s treatment?”

And the therapist is in the position in which the patient was. Now the therapist is like the prisoner confronted with a sadistic prison guard. Their roles have been reverted. And the therapist interprets that systematically: points out first the [inaudible]. And he will use metaphor to describe as clearly, as closely as possible the relationship that is now being activated. The therapist may say, “You know, it looks as if you were imprisoned in a dangerous setting where you’re being under the control of a sadistic interrogator.” And I might then tell the patient later on, once this relationship has been reverted, “I have a sense that now it’s you who is taking the role of the interrogator while I am the guilty prisoner who is being kind of corrected. So it is as if the same relation that we were examining ten minutes ago is now active again, but with reversed roles.”

That interpretive—on the surface—this just looks like “mentalization,” in the sense that you help the patient become aware of his mental state and of the mental state that he attributes to the therapist, and how the therapist experiences himself. But at the bottom, this is already an interpretation—this role reversal—because you point out to the patient that he has an internal identification with a complete object relation—a persecutor and a victim—that gets activated with role reversal because he projects different aspects onto
the other. But that constitutes a constellation that’s a disposition in
him. And over a period of time, that permits the patient to be able
to reflect on this internal disposition, become less afraid of it, be
more able to accept it. And separately from that, we do the same with
moment in which this relationship seems ideal. And the same process
happens with role reversal, but in an idealized position.

Patient is like a little baby with a mother who’s giving the patient
everything. The patient is basking in her love. And at other times,
the patient behaves as the greatest person who is graciously giving
his love and acceptance to the therapist for behaving well. “He’s a
good therapist, and he’s doing what he’s supposed to do.” It’s an ideal
relation in which the motherly function has now been taken over by
the patient, and the therapist is a happy baby—a dangerous position
for the therapist to be in because it feels good and one forgets that it’s
only one side.

So we analyze the roles and role reversals in both persecutory and
idealized relation. And that leads to the next phase, or the next step,
in which we interpret the splitting mechanism between these totally
contradictory relationships, and with this, complete the interpretation
of the primitive splitting mechanisms. And when that is done in all
areas, gradually identity is normalized.

So then, interpretation of the transference has three phases: first,
defining the dominant object relation at any moment in the middle
of all the chaos of each session; second, to define the role reversals,
both within the idealized and the persecutory relationship; third, to
integrate them interpretively.

As a classical example of that, one of my patients of one of the research
projects—this was a patient who had been brutally mistreated by
her mother throughout her childhood. Her mother was physically
abusive. Picked her up by one arm, threw her around the room, and
then against the wall. And the patient didn’t dare to go to gym during
her childhood because she had green and blue spots all over the body.
And that patient, in the treatment, became extremely violent. In one
session, she came with a pair of scissors and cut all my plants before I
had a chance to react to her saying, “It’s the end of the session. We are
stopping now. I’ll see you next session, and you will have to pay for these plants before the end of the month to continue the treatment.” Except that I didn’t say it so calmly as I am saying it now. I was really angry, and I showed it.

Owens: And you didn’t hide that from her. You didn’t hide your anger.

Kernberg: Well, if I had been able to, I would have hidden it, but I was just angry and didn’t control it. This same patient, on another occasion, slammed the door to my office in the hospital. At that time, it was an office that only had one door—a very thick door for privacy. At the end of the session, the patient wanted to leave; couldn’t open the door. She had broken the lock. It was after hours. Another patient was waiting outside. I called security. It took them 20 minutes to come and break down the door. That was a moment of real countertransference acting out, because the patient who had started the session enraged—that’s why she slammed the door—was now sitting in a chair, frightened, and said, “Dr. Kernberg.” And I said, “This session is over!” I just read a magazine—I was just enraged.

The next patient thought I had had a heart attack, you know. And this patient, at night, she would stay in the dark patio where I parked my car. I was Medical Director, those years, of the hospital. So it was a patio surrounded by the buildings all full of patients. And she would yell, “Otto you shithead, going home while everybody else is suffering here!” So that was the patient. Very aggressive and barely containable. But she eventually improved and was one of our big successes.

Owens: Well, you bring us right to an important point.

Kernberg: And I just want to point one interpretation toward the end of the treatment, in advanced stages. The patient said in one session, “You know, if you had a red telephone, and I had a red telephone—same as the President of the United States and the Secretary General of the Soviet Union—to prevent an atomic war—and I knew I could call you at any point whether you were sleeping or awake, teaching or having sex, or playing football, or whatever, you would interrupt whatever you were doing to talk with me—I would be perfectly all right.”
I told her that seemed to me perfectly natural, perfectly normal for a three-month-old baby. And she said, “Well, I’m not a three-month-old baby.” And I told her, “That’s your problem—that I have to be a perfect mother, which a three-month-old baby has the right to have, and be always available. Because as soon as I stop being a perfect mother, I become the horrible mother who was beating you up. So you desperately try to protect the kind of an ideal vision of me that is unrealistic and frail, to protect yourself against perceiving me as the most horrible enemy that you can imagine.” The patient was able to understand that. And that’s the kind of bridging interpretation that then helps to bring about solution of identity diffusion, radical changes of the personality, and marks advanced stages of the treatment.

Owens: That’s a very interesting example. And it does refer to any number of technical difficulties in treating someone with a borderline personality when the aggression is so overriding, whether it’s self-destructiveness or intrusiveness, there’s a lot of problems that therapists have to encounter.

SETTING LIMITS

Owens: So I’d be curious just to hear, kind of, in an over-arching way, something of how you think about containing some of that aggression so that treatment’s possible.

Kernberg: Several elements there. First of all, we establish clear rules of what the patient can do and what he can’t do. I have described to you already the strategy, or steps, and the techniques: interpretation, transference analysis. Now I’m coming to the tactics. And one tactic is namely tactic to deal with special difficulties, and one is the intensity of aggression. Already when we set up a contract, there are certain behaviors which we restrict. Any behavior that worsens the condition of the patient, that’s dangerous to the patient’s survival, or the treatment survival, we set by contract limits to it. Typical example is chronic suicidal behavior. I’m not talking about suicidal behavior as part of depression. We treat the depression. I’m talking about characterological types of suicide that are real equivalent to temper tantrums, that emerge from one day to the next.

And we tell the patient, “Well, you have a history of severe suicidal
attempts. They are dangerous; dangerous to your life. They’re very serious. So our understanding has to be that whenever you feel suicidal, you have two possibilities. One, to discuss it in the next session. That’s ideal. That’s perfectly appropriate. You should do that. But you may feel that you can’t control it, and then, what you have to do is go to an emergency room of your hospital. Be evaluated. If they want to hospitalize you, that’s fine. You let me know, and I continue the treatment once you’re out. Or, if it’s in my hospital, I may be able to see you at the hospital. But I won’t see you in between sessions. There’s no need to call me in between sessions, and you have your instructions. You feel suicidal, and either you discuss it in the next session, or you go into the hospital, whichever way you would prefer. That, in general, enrages patients because suicide acquires secondary gain, and efforts to control.

The conditions depend upon the nature of what the symptom is that you want to control. One of our patients stabbed herself in the vagina all the time. She had severe infections, pelvic infections. It was a mess. We told her, “Every time you stab yourself, you have to see your gynecologist. He treats you. He lets us know whether you can continue to be treated on an outpatient basis at this point, or whether you need to get in the hospital. With these conditions, we’re willing to treat you. But we won’t see you in between sessions. If you can control it, great, we’ll discuss it in the next session.”

Now, that limit-setting is accompanied by immediate interpretation in the transference of the implication of this limit setting. The setting limits doesn’t do the job by itself. It has to go hand-in-hand with how the patient perceives that, with the object relationship that is activated by the fact that you brutally suppress the right of the patient to behave in a self-destructive way. And what it means to the patient. So you interpret how the patient perceives your behavior, and, eventually, what that behavior means in itself. That combination of limit setting and the systematic interpretation of what has been controlled is what permits dramatic changes in the symptomatology from very early on.

The patient, whom I mentioned to you, was severely suicidal. This is what I did with her from the beginning of the treatment. And I don’t
have time to go into the detail of it, but she never—instead of coming
to the first session with me, she had a suicidal attack. So the first
session was really the second session. And I set that contract—spent
six or ten sessions only discussing the contract and interpreting her
reactions to it. And that’s how the treatment starts. It’s not a written
contract. It’s an understanding. And of course, there are many
complications. The patient may lie, and you explain what it would
mean if the patient lies, et cetera.

During the treatment, the patient can yell in the session, but limited
to the extent that it doesn’t disturb the work of other people who work
on the same floor. The patient cannot attack you physically. Don’t let
the patient attack the therapist physically, nor destroy objects in the
office, nor behave in gross, inappropriate way from the viewpoint of
ordinary social interaction. The patient, for example, would try to
assault sexually the therapist.

We’ve had a patient who tried to assault—she tried to assault the
therapist during a session in spite of the fact that it was being
videotaped. She didn’t care. Patient came to see me without any
underwear and spread her legs. So there are many ways in which
inappropriate behavior shows up. We point out that this is not what is
tolerated. We stop the session. Patient comes to the next session, and
we analyze what has been going on.

Owens: You set the limit and you accompany it with an interpretation.
That seems very essential part…

Kernberg: We set limits. And whenever we set limit, it goes hand
in hand with an interpretation of the meaning of our intervention
stopping the acting out in the session. That’s another important tactic.
We have developed a number of very helpful tactics. I can’t go into
all of them, but I want to mention one more, because again, it has to
do with patients with very severe aggression who develop powerful
psychotic episodes in the treatment. That is, paranoid regression in
patients who have not had a paranoid psychosis. And I will give you an
example: the patient, a physician with severe narcissistic personality,
severe sexual promiscuity who—I don’t give you the whole elements,
but he worked in the same medical complex in which I was working.
So he had dinner with a nurse, the nurse invited him to her home. He had dinner with her. He told her that he was in treatment with me, and she told him that she knew me. And later on, he tried to stay and have sex with her, and she refused to have sex. So he left, and as he left, he developed the idea that I have forbidden all of the nurses of the medical complex to have sex with him. And he came the next morning enraged, and wanted to beat me up because I had forbidden all the nurses from the hospital to have sex with him. And at first the whole thing seemed to be so absurd, I didn’t take it too seriously. And he got even more enraged because I was playing innocent.

So I first told him that I needed his assurance that I was safe and he was not going to attack me physically. If not, we had to stop the session. And he grudgingly granted that. And then, I applied that technique that I want to mention. I told the patient that he didn’t need to belabor the point, that I was convinced that he was convinced that I’d forbidden all the nurses to have sex with him. I didn’t question it. I knew that it was his firm conviction. Would he be able to let me tell him what my conviction was, or not?

“Okay, go ahead,” he said.

So I told him, “I think that this is completely mad to assume that I would do that. Completely crazy, out of reality, total madness. I would never do such a thing. I would not even think about such a thing. It has nothing to do with me at all.”

And the patient said, “Well, I didn’t say that you wanted to do that. It’s enough to roll your eyes, make a gesture. Everybody understands, ‘Stay away from that guy.’”

I insisted that I would never do that. “No, I am convinced, absolutely convinced, that this is false, I told you. I am not trying to convince you of it,” I told him. “You have to decide whether I am telling you the truth or whether I am lying. If you think that I am lying, then you have to talk about what it means that the therapist lies to his patient.”

By the way, we call that psychopathic transferences, when, you know the patient lies or attributes that to the therapist, and we analyze its unconscious meanings, which gradually transforms it into paranoid
transferences. Because if your patient lies or feels that he is being lied, is that really a fear that the truth may bring about horrible, aggressive consequences.

But the patient didn’t think that I was lying. So I said, “Okay, if you can believe that I’m telling you my truth, then you have to agree that one of the two of us is mad here. Because these are completely incompatible realities, and we have no witness. We can’t decide whether you are mad or whether I am mad in this situation. We can agree that there is madness, and we can analyze the nature of the madness without locating it in either you or me. And the content of this madness,” I said, “is that there is a powerful man who is interfering with another man having any sex with a woman. It’s really a powerful man who is castrating a weak man who depends on him.”

And the patient reacted with a memory of his father, a small-town physician who had a violent nature. One night, while the patient was a child, the two dogs of the father were barking. The father got enraged and cut the vocal cords of the two dogs, and the patient was horrified. Well, that was going on. It was a very dramatic change in the session. It was a psychotic transference. So that we were willing to deal with psychotic transfers with the technique of incompatible realities. We have a number of methods developed within the analytic approach that deal with severe aggression.

I don’t give you further examples of this, but the treatment consists of the combination of the general strategies, the techniques which come from psychoanalysis with some modification according to detail, and to the tactics that are applied to specific situations. For example, how to deal with patients with dissociative phenomenon, multiple personalities, the syndrome of arrogance that Bion describe—that we see patients who combine extreme verbal violence in the session with arrogance, curiosity about the therapist and pseudo-stupidity—a very primitive form of aggression in which what we have to do is to analyze the patient’s effort to erase all cognitive awareness of his aggression. So the expression of aggression, at the same time, serves the purpose to deny the awareness of it, and the awareness of the pleasure. So we interpret the defense against the pleasure of aggressive lashing out. Make that egosyntonic. And that has a very important function.
Owens: I was curious; do you set those conditions of the contract right at the beginning? Do you go over all of them, or do you respond to them as things emerge?

Kernberg: I set all those that I can see. Some patients don’t need any, and so I don’t set any. I set all those that seem necessary. And then, during the treatment, new things that pop up: the telephone caller that I haven’t discovered. And then in treatment, people who call me day and night. I control that. One practical principle that we have is, if I want to do a new control, I never make a decision during the session in which the idea comes to me. To prevent myself from countertransference acting-out. I always wait for the next session.

Dr. Owens: Yeah, you want some time to think and calm down a little bit. Yes, that makes a lot of sense. It’s easy to be reactive against some of these provocations, yeah.

USING COLLEGIAL SUPPORT

Owens: Dr. Kernberg, this has been very fascinating and informative, and I’m curious now, reflecting back on your career, in terms of what you know now you wish you had known when you began your career, an orientation to your work or perspective that you’ve gained. If you can speak to that, what is it now that you know that you’ve gained over the years of your practice and work?

Kernberg: Well, it’s hard to answer that because I’ve been gaining understanding how to treat these patients gradually. Each new case represents new challenges. I have been very fortunate in working with the group of co-workers at the Personalities Disorders Institute. It’s about 12 to 15 people who have been working together for, some of them, 30 years, helping each other, supervising each other’s cases.

Owens: How critical is that to you, that kind of collegial help?

Kernberg: Oh, essential. When you see these very severe patients, you can’t avoid that it gets under your skin from time to time. Then to have the help of colleagues helps you to deal with countertransference. I’ve learned that there are two types of countertransferences—the acute ones, changes in feelings from moment to moment in the sessions, and long-term distortions of your relation with a certain
patient, chronic countertransferences that are quite frequent with these patients. And they tend to restrict your perspective and reduce your internal freedom. And a group that helps you ventilate your concern about patients whom… “I want to talk with you about this patient. Things are not going well. I don’t know what’s going on.” Then it helps to work this through.

So it becomes—everybody, at every level of experience, needs a little group of colleagues whom we trust and with whom we can exchange information—from Freud to a first-year resident. That’s one thing I’ve learned.

**Owens:** That’s an important lesson, and that’s one that everyone I believe is aware of.

**Kernberg:** And you have to accept that you can’t help everybody. Some people you can’t help because somebody else might be able to help you, you can’t, some people because they can’t be helped. So I’m always accepting the possibility that I might not be helping the patient. And I tell the patient, if the patient says, “What would you do if…” I say, “I would have to accept that we are not getting anywhere.”

**Owens:** It sounds like that offers a freedom.

**Kernberg:** The patient tells me, “What will you do? What if I commit suicide?” I tell the patient, “I would feel very sad, but life would go on. I would do the same thing I am doing.”

**Owens:** Well, thank you very much, both for talking with us today in this interview, and also for your lifelong work. I appreciate it and admire it a great deal. Thank you.

**Kernberg:** You’re most welcome.
Video Credits

Producer: Victor Yalom
Interviewer: Terry Owens
Director of Photography: Corryn Cue
Post-Production & DVD Authoring: John Welch
DVD Artwork: Julie Giles
Still Photography: Rafal Mietkiewicz

Special thanks to Dr. Kernberg for sharing his wisdom and knowledge.

Copyright © 2010, Psychotherapy.net, LLC
Earn Continuing Education Credits for Watching Videos

Psychotherapy.net offers continuing education credits for watching this and other training videos. It is a simple, economical way for psychotherapists—both instructors and viewers—to earn CE credits, and a wonderful opportunity to build on workshop and classroom learning experiences.

* Visit our Continuing Education section at www.psychotherapy.net to register for courses and download supplementary reading material.

* After passing a brief online post-test you will be able to access and print your **Certificate of Completion** on our website. Voilà!

* **CE Approvals:** Psychotherapy.net is approved to offer CE courses for psychologists, counselors, social workers, addiction treatment specialists, and other mental health professionals.

* **CE Available for your Organization:** Our CE courses can be used for staff training; contact us for details.

Psychotherapy.net also offers CE Credits for reading **online psychotherapy articles** and **in-depth interviews** with master psychotherapists and the leading thinkers of our times.

To find out more, visit our website, www.psychotherapy.net, and click on the **CE Credits** link. Check back often, as new courses are added frequently.
About the Contributors

VIDEO PARTICIPANTS

Otto 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.

Terrence Owens, PhD is a San Francisco based psychologist and psychoanalyst. He is the clinical director and co-founder of the Masonic Center for Youth and Family, is on the faculty of the University of San Francisco and the San Francisco Center for Psychoanalysis, and was formerly the director of adolescent psychiatry at St. Mary’s Medical Center. He also maintains a private practice working with adolescents and adults in psychoanalysis and psychotherapy.

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.
More Psychotherapy.net Videos

We have videos covering a wide range of experts, approaches, therapeutic issues and populations.

We continually add new titles to our catalogue. Visit us at www.psychotherapy.net or call (800) 577-4762 for more information.

**Approaches**

- Adlerian Therapy
- Art Therapy
- Body-Oriented Therapy
- Brief Therapy
- Child Therapy
- Cognitive Behavioral Therapy
- Consultation/Supervision
- Couples Therapy
- Existential-Humanistic Therapy
- Family Therapy/Family Systems
- Gestalt Therapy
- Group Therapy
- Integrative Therapy
- Motivational Therapy
- Multicultural Therapy
- Narrative Therapy
- Object Relations Therapy
- Person-Centered Therapy
- Positive Psychology
- Psychodrama
- Psychodrama Therapy
- REBT
- Solutions-Focused Therapy

**Experts**

- Ellyn Bader
- Judith Beck
- Insoo Kim Berg
- James Bugental
- Albert Ellis
- Kenneth Hardy
- Sue Johnson
- Jeffrey Kottler
- Monica McGoldrick
- Donald Meichenbaum
- Scott Miller
- William Miller
- Jacob & Zerka Moreno
- Violet Oaklander
- Ernest Rossi
- David & Jill Scharff
Arnold Lazarus
Peter Levine
Rollo May
Martin Seligman
Irvin Yalom
...and more

**Therapeutic Issues**

Addiction
Anger Management
Alcoholism
ADD/ADHD
Anxiety
Beginning Therapists
Child Abuse
Culture & Diversity
Death & Dying
Depression
Divorce
Domestic Violence
Grief/Loss
Happiness
Infertility
Intellectualizing
Law & Ethics
Medical Illness
Parenting
PTSD
Relationships
Sexuality
Suicidality
Trauma
Weight Management

**Population**

Adolescents
African-American
Children
Couples
Families
GLBT
Inpatient Clients
Men
Military/Veterans
Parents
Prisoners
Step Families
Therapeutic Communities
Women