Aspects of malignant narcissism: Discussion of Otto Kernberg's paper, PSYCHOPATHIC, PARANOID AND DEPRESSIVE TRANFERENCE

Marcin Hurwich, Ph.D.


In his distinguished and remarkably productive career as a psychoanalyst, Otto Kernberg has focused on difficult and inadequately understood conditions. His work has resulted in the more fruitful utilization of psychoanalytic concepts with disturbed patients, and the stimulation of a new body of psychoanalytically based conceptualizations. He has demonstrated an unusual capacity for synthesizing diverse areas of interest within our field, beginning with the integration of Hartmann's ego psychology and Melanie Klein's object relations theories (1966).

Kernberg reconceptualized the ill-defined conditions labeled borderline state, borderline psychosis, latent schizophrenia, etc., as a level of personality organization that can be differentiated from neurosis on the one side, and from psychosis on the other. He delineated the major distinguishing characteristics of borderline personality organization in terms of ego processes and internalized object relations. He underscored specific and non-specific ego weaknesses and described pathology of internalized object relations. He implicated the predominance of excessive levels of early aggression in the pathogenesis of these conditions (1967) and specified differential diagnostic criteria, especially the maintenance of reality testing, the predominance of primitive defensive functioning and the presence of identity diffusion (1977).

Kernberg's main points in the paper can be divided into the following areas: clarification of various transference paradigms associated with superego pathology: specifically, psychopathic, paranoid and depressive; specification of the progressions, shifts and interrelationships among these transferences with such patients; demonstration of how he works with conscious deceptiveness by these patients, and the rationale for his interventions. My discussion will be selective, and not all the important issues can here be discussed in the detail which their importance merits. I will focus especially on the concept of malignant narcissism, and on the paranoid transferences.

In addition to his major work on borderline personality organization, Kernberg
has made noteworthy contributions to the understanding of narcissistic character pathology. A brief review of some of his earlier formulations will serve as an introduction to the discussion of today's paper. In his 1970 paper on the psychodynamic treatment of narcissistic personalities, Kernberg described the clinical features of the narcissistic personality as follows: an unusual degree of self-reference, and a great need to be loved and admired, reflected in an inflated view of self on the one hand, and an excessive need for praise on the other. Relationships of these individuals are exploitive, distrustful, ruthless and sometime parasitic, with little empathy toward others. There is a shallow emotional life, and little enjoyment experienced other than from grandiose fantasies, or from praise. There is inordinate envy of others, idealization of those from whom narcissistic supplies are desired and contemptuous treatment and devaluation of others. There is restlessness and boredom when self-esteem is not being nourished, and a sense of the right to control and exploit others without guilt feelings. There is deep distrust and depreciation of others with underlying ruthlessness and coldness characteristically masked by a surface charm.

In this just described paper, Kernberg remarked on the guarded prognosis for these patients, and on the severity of the transference resistances encountered, due to the need to deny dependency. He nevertheless expressed the opinion that some patients with central narcissistic character pathology do improve with psychodynamic treatment. And he held that psychoanalysis is the treatment of choice except for those narcissistic personalities who are functioning at a borderline level. For these latter patients he recommended a supportive approach (pp. 72-3). And he included the following caveat: "Patients who lie to the analyst over a long period of time, as well as to other people, or present other forms of antisocial behavior, have a bad prognosis. He continues, "It almost goes without saying that the antisocial personality structure, which represents an extreme form of the lack of superego development, has the worst prognosis of all" (p. 77).

In the paper discussed in this presentation, Kernberg focuses on the psychoanalytic treatment of cases of malignant narcissism, which has important features in common with the kinds of narcissistic pathology described in 1970 as having a poor, close to hopeless prognosis. He has detailed three main features of malignant narcissism: ego syntonic aggression, antisocial behavior, and paranoid features. This concept of malignant narcissism, discussed in some detail in 1984, constitutes a further specification of the darker side of narcissistic pathology, and of the human potential more generally. Superego pathology is a key underlying factor, and the condition is limited to patients functioning at the borderline level of psychic organization. In the earlier formulations of borderline personality organization per se, Kernberg pointed to the degree of superego integration as a prognostic factor for successful long-term intensive psychotherapy. In the current presentation, he further elaborates on some consequences of superego deficiencies for the treatment of borderline patients who centrally demonstrate manifestations of malignant narcissism.
Cases of malignant narcissism are among the most difficult to treat in all psychopathology. Above the psychotic range, only the full blown antisocial personality is more difficult, a condition that defines the outer limit of treatability within a framework of psychoanalytically based psychotherapy. While antisocial features constitute a criterion for malignant narcissism, Kernberg has explicitly differentiated the antisocial factors found in this grouping from the antisocial personality proper. Most experienced clinicians, over the years have worked with some patients who showed malignant forms of narcissistic character pathology as defined by Kernberg. One can readily agree with the opinion that these cases merit a guarded prognosis, and many would claim that such patients are untreatable with psychoanalytic psychotherapy or with any other method.

If taken into treatment, these patients present difficult therapeutic challenges, involve an increased likelihood of stalemates and failed outcomes, and tend to engender considerable counter-transference reactivity. It is a tribute to Kernberg that he has been able to find ways to work with such patients utilizing a psychoanalytic framework, and creatively employing as well as extending existing technical procedures.

It is also noteworthy that Kernberg’s conception of malignant narcissism is different in consequential ways from the kinds of narcissistic pathology described and formulated by Kohut and the self psychologists. While Kohut has given consideration to narcissistic rage and to exploitation (1972), his work on narcissism could be characterized as focusing on the more benign forms of narcissistic pathology as compared to Kernberg’s focus on the more malignant aspects.

Here are some thoughts about the concept of malignant narcissism stimulated by Kernberg’s paper.

It is useful to make explicit that each of the defining criteria can be understood as a variable, and that clinical cases will differ somewhat depending on the relative strength and specific qualities of the three criterion variables.

With regard to the individual defining characteristics, the following questions can be raised for each case:

— To what extent does the ego syntonic aggression include physical manifestations, such as assaultiveness or malicious mischief, or physical torture, etc. This issue is already implied by Dr. Kernberg in his second criterion of antisocial behavior, but is consequential enough to merit explicit mention.

— To what extent does the ego syntonic aggression serve self-esteem regulation. For individuals who experienced their formative years as entailing deprivation and neglect in conjunction with excessive blame, domination and control, the expression of aggression involves an active perpetration by the victim of what he had helplessly suffered earlier. And for such a person, the expression of hostility can be associated with feelings of adequacy, safety and self-enhancement, while the inhibition of a hostile aggressive reaction results in feelings of inadequacy, danger and self-degradation. To the extent that the aggressive expression is a central self-esteem regulator, resistance to curbing the aggression will be formi-
dable. Likewise, to the extent that the overt aggressive behavior serves as a defense against feelings of helpless vulnerability and danger, there is additional resistance to controlling the aggression. The most difficult circumstance is when the aggression serves both trends, in a framework of poor impulse control and superego deficits.

The aggressive discharge can also be pleasurable to the patient, providing an invigorating, gratifying lift, much more enjoyable than the tame, puny and colorless feelings the patient gets when he/she expresses emotions in an “adult” way. I have found some patients with major features of malignant narcissism to experience my focusing the defensive and protective meanings of the aggressive behavior as an attempt to take from them what they most need to protect themselves from fears of being psychically destroyed. As one patient put it:

“The act of hate is a way of ridding myself of what they’ve done to me. It’s a way of defending myself against my parents. If I could kill them, then I could prove to myself that they did not destroy me. It would show that I am strong enough to defend myself. It means I’m strong, not an incompetent, worthless freak. Hate for me is a way of self protection and enhancement.”

— To what extent is the ego syntonic aggression associated with pathological envy, which involves the urge to destroy the object of one’s envy. Here, the issues of revenge and pathological self-esteem regulation are central, and can be an integral aspect of a negative therapeutic reaction, where the patient is motivated to stymie the treatment so as to prevent the therapist from having a sense of accomplishment. Kernberg has written about this form of unconscious envy, but does not see it as a component of malignant narcissism (1984).

As I thought about this definitional choice, the queen in the story of Snow White came to mind. First she failed to get the confirmation for her grandiose need to be the fairest of all. When she learns that Snow White is seen to be more beautiful, she commands that Snow White be killed. Such a reaction reflects pathological envy leading to pathological revenge. The ego syntonic aggression and the antisocial trends are both manifestly there. And the queen’s described behavior also reflects paranoid features, thus meeting Kernberg’s criteria for malignant narcissism. The formulation does not rule out the Oedipal implications of the queen’s rivalry with Snow White.

Perhaps Dr. Kernberg would say that it was not the envy or the revenge per se that were pathognomonic of malignant narcissism. And as he has defined the condition, he would be right about that. Still, if the word malignant in the designation malignant narcissism means harmful, dangerous and virulent, then it would be consistent and useful to include the virulent form of all the major aspects of narcissistic pathology in the description of malignant narcissism, even if the accessory manifestations are not themselves necessary or sufficient for the diagnosis. I have the impression that Kernberg’s extensive discussion of malignant narcissism in his book, Severe Personality Disorders (1984) does include some consideration of these related, but diagnostically secondary manifestations. My next thought was about the pathological revenge taken by Medea following a narcissistic injury
perpetrated by her husband. I will resist the temptation to assess here to what
extent she also would qualify for the malignant narcissism diagnosis.

— Regarding anti-social values: to what extent do these involve, in addition to
the penchant for lying, the presence of ruthlessness in achieving personal control,
power, confirmation of attractiveness, and/or greatness.

— Under what conditions, and to what extent is the persecutory superego layer
predominant over the idealizing layer, and the more realistically determined top
layer (Jacobson, 1964).

— To what extent, and in what ways does the patient demonstrate concern and
lack of concern for others (Winnicott, 1963).

— A number of these same questions could be raised with regard to paranoid
features, which will not be further explored here.

— To what extent does the ego syntonic aggression serve grandiose ambitions
for power and control over others. The tycoon personality, and some political
leaders, especially dictators and tyrants, would be examples.

These latter individuals are capable of causing great harm to others. It remains
ture that there is an increased risk of error in drawing conclusions about psychopa-
thology from public behavior as opposed to first hand clinical data. Nevertheless
the presence of ego syntonic aggression, antisocial behavior and paranoid features
are strongly suggested in the personality structure of Hitler, Stalin, and most
recently, Saddam Hussein. Nor is earlier history devoid of such tyrants, from the
Pharaohs to the Caesars to the Borgias. Albert Camus has captured this most
malignant form of malignant narcissism in his drama Caligula. In such individuals,
in addition to the triad of characteristics delineated by Kernberg for his clinical
description, is found megalomaniac grandiosity. Here is an apt description from

“They have attained absolute power; their word is the ultimate judgment of
everything, including life and death; there seems to be no limit to their capacity to
do what they want. They are gods, limited only by illness, age and death. They try
to find a solution to the problem of human existence by the desperate attempt to
transcend the limitation of human existence. They try to pretend there is no limit
to their lust and their power...[but] The more he tries to be god, the more he
isolates himself from the human race; this isolation makes him more frightened,
everybody becomes his enemy, and in order to stand the resulting fright he has to
to increase his power, his ruthlessness and his narcissism. This Caesarian madness
would be nothing but plain insanity were it not for one factor: by his power Caesar
has bent reality to his narcissistic fantasies. He has forced everybody to agree that
he is the most powerful and the wisest of men — hence his megalomania seems to
be a reasonable feeling. On the other hand, many will hate him, try to overthrow
and kill him — hence his pathological suspicions are backed by a nucleus of
reality. As a result he does not feel disconnected from reality — hence he can keep
a modicum of sanity, even though in a precarious state” (p.66).

It is likely that many known and less well known individuals who qualify for
the diagnosis of malignant narcissism will not seek psychotherapy. But Kernberg’s
demonstration of how he has worked with some of these cases is illuminating both
for dealing with malignant narcissism, and for other related, difficult characterological
pictures.

TRANSFERENCE MODES FOUND IN THE
TREATMENT OF MALIGNANT NARCISSISM

Freud’s use of the concept of transference goes back to the Studies in Hysteria
(1985). While over the years Freud used this most central psychoanalytic concept
to include a range of phenomena, the unvarying feature was the repetition in the
present of past attitudes.

Anna Freud, in her 1936 book, The Ego and the Mechanisms of Defense, added the
transference of defense, i.e., the repetition with the analyst of a defensive maneu-
er used at an earlier age. The concept of character defense was elaborated in the
early 1930’s by Wilhelm Reich, who stressed that character neuroses substituted
eo syntonic defensive modes for ego alien symptoms. He conceptualized a layer-
ing of defensive processes, and recommended a systematic approach to analyzing
the defensively molded character armor before attempting to work with the under-
lying conflicts. The notion that defensive processes are interrelated in various
ways, and of a defensive hierarchy is consistent with Freud’s view of a series of
censorships, and in the work of Jones (1929), Glover (1936), Gero (1951), Fenichel
(1940), Rapaport (1951), and Gill (1963) among others.

What Dr. Kernberg has offered in this paper, is a specification of how borderline
patients with malignant narcissism elaborate a sequence or hierarchy of transfer-
ence manifestations in long-term psychoanalytically based psychotherapy.

A first major point is that psychopathic and perverse transferences reflect deeply
pathological narcissism. By psychopathic transferences Kernberg means those times
in the treatment when the patient is being deceitful and projects the deceitfulness
onto the analyst. By perverse transferences he means where the patient takes
whatever may be helpful from the analyst, and turns it into something damaging
and bad: he derives pleasure from turning love into hate.

Kernberg demonstrates with his case examples, how both perverse and psychop-
athic transferences shift into paranoid transference in the course of the treatment.
Always careful to make consequential diagnostic distinctions, Kernberg empha-
sizes that when the features of malignant narcissism are absent, narcissistic trans-
ferences are more likely to shift into depressive transferences. These are very
useful distinctions and clinical guidelines for clinicians working with such unusu-
ally difficult patients.

In recognizing these typical developments in the psychotherapy of patients
with malignant narcissism, Kernberg has defined some new forms of narcissistic
transferences, which complement Kohut’s specification of the mirroring and ideal-
izing narcissistic transferences. I do not mean to imply anything about Kernberg’s
views on these aspects of Kohut's work. Rather, I am calling attention to the fact that Kohut specified two new forms of transference which he believed typify narcissistic character pathology as he understood and defined it (1974). Kernberg's paper includes a parallel delineation of some typical transference dispositions and interrelationships found in narcissistic patients with what Kernberg has defined and described as malignant narcissism.

We are provided with a formulation of key elements in a therapeutic strategy for dealing with these patients. A major recommendation Kernberg makes is to focus and confront conscious withholding of thoughts, and ego syntonic lying. Of course, the concepts of a dynamic unconscious, and of unconsciously motivated defense activity render all patients (and all non-patients as well), unwitting tellers of untruths. And the withholding of embarrassing thoughts and long held secrets, especially in the early phases of psychotherapy, is very frequent. Indeed, the revelation to the psychotherapist of a personal secret about which the patient feels embarrassed, and which he may never have previously shared is a well known phenomenon which frequently indicates an increasing trust and involvement in the treatment.

But these are not the kinds of things Dr. Kernberg is focusing on in his paper. Rather, he is referring to cases where there is conscious withholding of material, accusations of the therapist's dishonesty, and lying. For this psychopathic transference, Kernberg recommends forthright and timely confrontation. Such an intervention does not usually result initially in a reflective response by the kind of patient under consideration, but rather in an angry, accusatory retort which ushers in the paranoid transference. Kernberg has demonstrated how he responds by underscoring the incompatible realities between himself and the patient, and by pointing out contradictions in the patient's position and offering clarifications of illogical assumptions implied by it. In these interventions, Kernberg is providing the patient with opportunities to use his/her capacities for reflective awareness; judgment and reality testing, as a first step in correcting the distortion. In addition; this confrontation and the follow-through can lead to a deepening of the therapeutic work, as his paper demonstrates.

The decision of how to deal with incompatible realities between patient and therapist very much depends on diagnostic considerations. When the patient's reality is delusional, a direct confrontation is usually counterproductive, because his investment in the delusional idea exceeds his capacity to bring to bear the requisite reflective awareness necessary to evaluate his position more objectively. Attempts to assure him that he is mistaken have been found to reinforce the patient's belief. Why else, would you go to such lengths to reassure him that he is wrong if you weren't lying (Margaret Sechah'se's patient Renee reported just such a response.) (1951).

On the other hand, Arieti (1974) has reported a way to get at the delusion by demonstrating to the patient that he tends to experience such ideas just after certain key conflictual issues have been activated in him. If the patient can verify
this sequence, a therapeutic consideration of the delusion becomes possible.

Another approach to incompatible realities between patient and therapist has been referred to as siding with the defense. It can be employed with psychotic and non-psychotic patients. A dramatic example was provided by J.L. Moreno (the originator of Psychodrama). In the late 1940s, when informed that a man in an agitated state had just presented himself to the admissions clerk at the sanitarium (located in Hastings on the Hudson) claiming that he was Adolph Hitler, Moreno immediately asked two particular staff people to come into his office. One was portly, the other thin. After a short huddle, Moreno and the two co-workers strode out into the waiting area, clicked their heels, raised their right arm in a Nazi salute, and shouted, HEIL HITLER! Moreno then said: "Mr. Hitler, here are Mr. Goring and Mr. Goebels."

Another example of working with incompatible realities was provided by Robert Lindner in his book The Fifty Minute Hour. Here the analyst delves into his scientist patient's delusional system sufficiently to allow him to confront the patient with inconsistencies in the patients account, which has the effect, we could say, of driving the patient SANE, by inducing him to reconsider the logical incompatibilities within his delusional system. Delusional systems do differ with regard to their logical coherence, though they all are based on false premises.

It does make a difference whether one is dealing with a borderline or a psychotic structure, and the relative strength of the paranoid elements in relations to the availability of reflective awareness in the clinical picture. Also relevant is whether the unrealistic idea arises in the course of treatment, in relation to the analyst.

Kernberg has convincingly demonstrated the value of confronting dishonesty and incompatible realities when psychopathic transferences are dominant, and under conditions of impasse. In his discussion of the heightening and resolution of the paranoid transference, Kernberg has described in Mr. C., an example of the delusional idea that the therapist had spat on the street upon seeing the patient prior to the session. Here, at a certain point in the treatment, a delusional idea has come to dominate the transference in a borderline patient with strong paranoid personality features. The patient further conveys his belief that the therapist is lying to him in denying the allegation, and tells of feeling assaultive urges.

In responding to the accusation, Kernberg explicitly reiterates the incorrectness of the patient's belief, in a way that communicates his concern and his attempt to get through to the patient. When the patient then expresses the view that the therapist probably didn't realize he had seen the patient on the street and that he had then spat on the ground, Kernberg underscores the incompatibility of their views on the matter, and asserts that there is thus some madness here, but he leaves open who is incorrect. Additionally, he interprets the patient's assaultive urges as reflecting a desire to trigger a fight between them which would confirm his own view of what the therapist had done on the street, and to deny the incompatibility between their alternate positions.

Here, two aspects of Kernberg's intervention are noteworthy. First, he has
deliberately chosen not to interpret the projective identification he hypothesizes to be reflected in the accusation, because of the delusional nature of the transference distortion. Instead, he highlights the incompatibility, and points out to the patient how his wishes to beat up the analyst constitute a defense against recognizing the incongruity between them.

Secondly, he avoided a major countertransference pitfall through the tone of this response. Kemenberg understood that the patient's unconscious attempt to project his own hostile, derogatory intent onto him also included the motive of inducing these angry feelings in the therapist. By not responding with an introjective identification—i.e., by not responding in the angry manner the patient was unconsciously attempting to induce him to do, a repetitive, pathological re-enactment was avoided. The patient's responses of crying, asking for forgiveness, expressing intense love for the therapist, and fears of homosexual implications confirm the therapeutic relevance of the intervention.

Because the shift from negative to positive feelings towards him had been so dramatic, Kernberg suspected that the delusional experience probably had not been resolved, but that instead the all bad transference figure had now changed into an all good one. So he did some further work on the delusional distortion, and was subsequently able to get to relevant underlying fantasies.

Here is psychoanalytic psychotherapy being practiced by a master of the art. Kernberg illustrates for us how his interventions are chosen on the basis of his clinical reasoning in conjunction with an evaluation which takes account of specific dynamic, defensive, diagnostic and reality considerations. And the distinctions he makes are instructive. For example, he emphasizes that he would not have dealt with a transference delusion like that of Mr. C. if the patient showed a generalized loss of reality testing. And he further underscores the importance of carefully evaluating the status of the impulse control, the extent of conventional morality, and how integrated the patient’s ego syntonic aggression is, to arrive at an assessment of the likelihood of dangerous acting out in the paranoid regression.

What follows is an alternate handling of Mr. C.’s delusional transference distortion. I agree with the assumption made by Kemenberg, and supported by the patient’s response to the key interventions summarized above, that the delusional transference (the patient’s conviction that the therapist had spat when he saw the patient) was based on an encapsulated psychotic nucleus, and not on the degree of loss of reality testing found in a paranoid psychosis. The patient’s acknowledgment of his error as described by Kernberg attests to the absence of the delusional fixity characteristic of a psychotic level of organization (Frosch, 1967).

The alternate handling would begin with not interpreting the projective identification, and thus far would coincide with Kernberg’s first move. The next step would be based on the assumption that the conduct of the treatment up to this point had readied the patient to externalize onto the analyst, aspects of an image of a sadistic, derogatory parent. If the analyst were to explore the patient’s fantasies and reactions surrounding this set of attitudes now externalized onto the analyst, the patient would have opportunities to review and correct the distortions.
This approach would perhaps not have triggered the disruptive wish to attack the analyst for challenging the distortion, and would have offered the opportunity for some additional living out in the transference, now crystallized around this fantasy, aspects of the hateful internalized object relation with the parents as it has come to be represented in the patient's mind.

It is here assumed that the patient's dramatic reaction to Kernberg's confrontation was partly due to the understanding and sincere tone in which it was delivered. But it also likely involved a masochistic, homosexual surrender to the overpowering father. This hypothesis is based on the details of the patient's response of crying, asking for forgiveness, and asserting his feelings of love for the recently hated analyst. Additionally, the history shows that the father was sadistic, regularly beat the children, and that the patient felt himself to be the preferred target for not only the father's hostility, but also of the rejection and teasing of the older brother, no doubt heightened as a result of the father's aggressive behavior.

Kernberg pointed out that the positive feelings expressed by the patient in response to his posing of the incompatible realities in a concerned way did not reflect a resolution of the relevant negative transference. It was on this basis that he returned to the exploration of the delusional distortion and was able to uncover additional and deeper fantasies of maternal as well as paternal images.

The question being posed is whether the confrontation of the incompatible realities triggered a sado-masochistic re-enactment in the transference. And, to what extent this served the therapeutic aims better than would an approach which focused the transference distortion without triggering what can be seen as a masochistic surrender.

The therapeutic advantage of not responding with an introjective identification, which Dr. Kernberg achieved, would also be gained by providing what Bion (1959) has called the containing function of the analyst. And it would allow for the possibility that the patient could correct the distortion as a result of the opportunities provided by prolonging the externalization.

On the other hand, what is here hypothesized as a masochistic surrender could also reflect a needed idealization of the analyst, in a paranoid personality who was not sufficiently able to idealize a sadistic father, and instead had to internalize the sadomasochistic trends on a defensive basis. And additionally, the confrontation, with the patient in a way being forced to acknowledge his factual distortion, and to his need to apologize, may have played an important role in readying the patient to explore the deeper sources of the distortion, as a result of acknowledging the father as a representative of reality. This is something all children have to do, and because of his history of excessive negative feelings toward his father, he perhaps did not sufficiently do. I cannot include anything in these formulations regarding what no doubt are important contributions to all this of experiences and subsequent fantasies regarding the mother.

This alternate way of handling the patient's transference distortion just described raises the question of the advantage of the direct confrontation of the
incompatibility in a case where the capacity for reflective awareness is basically intact, where no conscious deception is involved, and where the analyst's response to the patient does not allow the projective identification to work in the service of a non-therapeutic re-enactment.

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