AGGRESSION IN PERSONALITY DISORDERS AND PERVERSIONS

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Part I THE ROLE OF AFFECTS IN PSYCHOANALYTIC THEORY

Chapter 1 NEW PERSPECTIVES ON DRIVE THEORY

Marjorie Brierley (1937) was the first to point to a strange paradox regarding the role of affects in psychoanalytic theory and practice. Affects, she said, play a central role in the clinical situation but a peripheral and ambiguous one in psychoanalytic theory. Brierley thought that if the part played by affects could be clarified, this might help to clarify still unresolved issues in drive theory. The paradox Brierley described a half century ago seems to have persisted until recently. Only in the past ten years has this situation begun to change. After reexamining the relation between affects and drives in psychoanalytic theory, including Freud's changing theories of drives and affects and recent psychoanalytic contributions—including my own—to these issues, I am offering a revised psychoanalytic theory of affects and drives. I then examine the nature of affects as they emerge in the psychoanalytic situation and their distortions under the impact of defensive processes. Finally, I offer a developmental model based upon my conceptual frame.

DRIVES AND INSTINCTS

Although Freud believed that the drives, which he saw as the ultimate psychic motivational systems, had biological sources, he repeatedly stressed the lack of available information regarding the process that would transform these biological sources into psychic motivation. He conceived of libido, or the sexual drive, as a hierarchically supraordinate organization of partial sexual drives from an earlier developmental phase. This idea is in accordance with his concept of drives as psychic in nature. According to Freud (1905), the partial drives

(oral, anal, voyeuristic, sadistic, and so on) are psychologically integrated in the course of development and are not physiologically linked to each other. The dual drive theory of sexuality and aggression (1920) represents his final classification of drives as the ultimate source of unconscious psychic conflict and psychic structure formation.

While Freud described biological sources of the sexual drives according to the excitability of the erotogenic zones, he did not describe such specific and concrete biological sources for aggression. In contrast to the fixed sources of libido, he characterized the aims and objects of both libidinal and aggressive drives as changing throughout psychic development; he described continuity of sexual and aggressive motivations in a broad variety of complex psychic developments.

As Holder (1970) has pointed out, Freud clearly differentiated drives from instincts. He saw the drives as supraordinate; they were constant rather than intermittent sources of motivation. Instincts, on the other hand, were biological, inherited, and intermittent in that they were activated by physiological and/or environmental stimulation. Libido is a drive; hunger is an instinct. Freud conceived of drives as on the boundary between the physical and the mental, as psychic processes rooted in biology; he proposed (1915b, 1915c) that the only way we can know about drives is through their psychic representatives—ideas and affects.

Both Holder and Laplanche and Pontalis (1973, pp. 214–217) have stressed the purely psychic nature of Freud's dual drive theory and have charged that the distinction between psychological drives and biological instincts is lost in the *Standard Edition*'s translation of both *Instinkt* and *Trieb* as "instinct." I would add that the Strachey translation has had the unfortunate effect of linking Freud's drive concept too closely with biology, inhibiting psychoanalytic research into the nature of the mediating processes that bridge biological instincts with drives, defined as purely psychic motivation. The very term *instinct* stresses the biological realm of this concept and thus discourages psychoanalytic exploration of motivation. In my opinion, the concept of drives as hierarchically supraordinate psychic motivational systems is valid, and Freud's dual drive theory is satisfactory to explain such motivation.

As Laplanche and Pontalis (1973) appropriately note, Freud always referred to instincts as discontinuous inherited behavior patterns that vary little from one member of the species to another. It is impressive how closely Freud's concept of instinct parallels modern instinct theory in biology, as represented, for example, by Lorenz (1963), Tinbergen (1951), and Wilson (1975). These investigators consider instincts to be hierarchical organizations of biologically determined perceptive, behavioral, and communicative patterns released by environmental factors that activate

inborn releasing mechanisms. This biological-environmental system is considered epigenetic. Lorenz and Tinbergen showed in their animal research that the maturational and developmental linkage of discrete inborn behavior patterns, their overall organization within a particular individual, is very much determined by the nature of environmental stimulation: hierarchically organized instincts represent the integration of inborn dispositions with environmentally determined learning. Instincts, in this view, are hierarchically organized biological motivational systems. They are usually classified along the lines of feeding behavior, fight-flight behavior, mating, and other such dimensions.

Rapaport (1953) describes how Freud changed his concept of affects over the years. He originally (1894) considered them pretty much equivalent to drives; by 1915 (1915b, 1915c) he considered them (particularly their pleasurable or painful, psychomotor, and neurovegetative features) to be discharge processes of drives; eventually (1926), he considered them to be inborn dispositions (thresholds and channels) of the ego.

In my view, affects are instinctive structures—that is, biologically given, developmentally activated psychophysiological patterns. It is the psychic aspect of the patterns that becomes organized to constitute the aggressive and libidinal drives Freud described. The partial sexual drives, in this view, are more limited, restricted integrations of corresponding affect states, and libido as a drive is the hierarchically supraordinate integration of them—that is, the integration of all erotically centered affect states. In contrast to the still quite prevalent view within psychoanalysis of affects as merely discharge processes, I consider them to be the bridging structures between biological instincts and psychic drives. Supporting arguments for this conclusion will follow further elaboration of my definitions of affects and emotions.

AFFECTS AND EMOTIONS

Following Brierley (1937) and Jacobson (1953) from the clinical psychoanalytic field, and Arnold (1970a, 1970b), Izard (1978), Knapp (1978), and Emde (1987; Emde et al. 1978) from the field of empirical research on affective behavior in neuropsychology, I define affects as psychophysiological behavior patterns that include a specific cognitive appraisal, a specific facial pattern, a subjective experience of a pleasurable and rewarding or painful and aversive nature, and a muscular and neurovegetative discharge pattern. The expressive facial pattern is part of the general communicative pattern that differentiates each particular affect.

There is fairly general agreement today that affects from their very origin have a cognitive aspect, that they contain at least an appraisal of

the "goodness" or "badness" of the immediate perceptive constellation, and that this appraisal, in Arnold's (1970a, 1970b) formulation, determines a felt motivation for action either toward or away from a certain stimulus or situation. In contrast to the older James-Lange theory (James 1884; Lange 1885), which held that the subjective and cognitive aspects of affects follow or are derived from the perception of the muscular and neurovegetative discharge phenomena, and in contrast to the derived position of Tomkins (1970) that the cognitive and felt aspects of affects follow or are derived from the perception of their facial expression, I think that the subjective quality of felt appraisal is the core characteristic of each affect.

I see affects as either primitive or derived. Primitive affects make their appearance within the first two or three years of life and have an intense, global quality and a diffuse, not well-differentiated cognitive element. Derived affects are more complex, consisting of combinations of the primitive affects, cognitively elaborated. Unlike primitive affects, they may not display all their original components with equal strength, and their psychic aspects gradually come to dominate the psychophysiological and facial communicative ones. For these more complex phenomena I would reserve the term *emotions* or *feelings*. This distinction corresponds to the clinical observations regarding primitive affect states and complex emotional developments in the psychoanalytic situation.

AFFECTS AND DRIVES

In Freud's first theory of affect the concepts of affect and drive were practically interchangeable. In his second affect theory, Freud proposed that drives are manifest by means of psychic representations or ideas—that is, cognitive expressions of the drive—and affects. Affects, he postulated, are discharge processes that may reach consciousness but do not undergo repression; only the mental representation of the drive is repressed, together with a memory of or a disposition to activate the corresponding affect (1915b, 1915c).

In clinical psychoanalysis, the idea that affects cannot be dynamically unconscious has been a conceptual problem, and it is possible that Freud's exclusive stress on the discharge aspects of affects in his second theory was to some extent a consequence of the then-dominant James-Lange theory. In any case, we now have important neuropsychological evidence that affects may be stored in the limbic brain structures as affective memory (Arnold 1984, chaps. 11, 12).

If affects and emotions include subjective experiences of pain or pleasure and cognitive and expressive-communicative elements as well as

neurovegetative discharge patterns, and if they are present—as infant research has demonstrated (Emde et al. 1978; Izard 1978; Stern 1985; Emde 1987)—from the earliest weeks and months of life, are they the primary motivational forces of psychic development? If they include both cognitive and affective features, what does the broader concept of drive contain that is not contained in the concept of affect? Freud implied that the drives are present from birth on, but he also implied that they mature and develop. It may be argued that the maturation and development of affects are expressions of the underlying drives, but if all the functions and manifestations of drives can be included in the functions and manifestations of developing affects, it would be difficult to sustain a concept of independent drives underlying the organization of affects. In fact, the transformation of affects throughout development, their integration with internalized object relations, their overall developing dichotomy into pleasurable affects building up the libidinal series and painful affects building up the aggressive series, all point to the enormous richness and complexity of their cognitive as well as affective elements.

I believe the traditional psychoanalytic concept of affects as discharge processes only and the assumption that decrease of psychic tension leads to pleasure and increase to unpleasure have unnecessarily complicated the understanding of affects in the clinical situation. Jacobson (1953) called attention to the fact that tension states (such as sexual excitement) may be pleasurable and discharge states (such as anxiety) may be unpleasurable; she concluded, in agreement with Brierley (1937), that affects are not solely discharge processes but complex and sustained intrapsychic tension phenomena.

Jacobson also described how the cognitive aspects of affects refer to their investment of self and object representations in both ego and superego. She concluded that affective investments of these representations constitute the clinical manifestations of drives. In other words, whenever a drive derivative is diagnosed in the clinical situation—for example, a sexual or aggressive impulse—the patient is invariably experiencing at that point an image or representation of the self relating to an image or representation of another person ("object") under the impact of the corresponding sexual or aggressive affect. And whenever a patient's affect state is explored, a cognitive aspect is found, usually a relation of the self to an object under the impact of the affect state. The cognitive elements of drives, Jacobson said, are represented by the cognitive relations between self and object representations, and between self and actual objects. Sandler (Sandler and Rosenblatt 1962; Sandler and Sandler 1978) reached similar conclusions regarding the intimate connection between effects and internalized object relations.

In clarifying the relationship between affects and moods, Jacobson (1957b) defined moods as a temporary fixation and generalization of affects throughout the entire world of internalized object relations—that is, a generalization of an affect state throughout all the individual's self and object representations for a limited time span: moods are thus extended yet relatively subdued affect states that color, for a time, the entire world of internalized object relations.

AFFECT AND OBJECT

I propose that early affect development is based on a direct fixation of early, affectively imbued object relations in the form of affective memory. Indeed, the works of Emde, Izard, and Stern all point to the central function of object relations in activating affects.

Different affect states toward the same object are activated under the dominance of various developmental tasks and biologically activated instinctive behavior patterns. The variety of affect states directed to the same object may provide an economic explanation for how affects are linked and transformed into a supraordinate motivational series, which becomes the sexual or aggressive drive. For example, the pleasurable oral stimulations during nursing and the pleasurable anal stimulation during toilet training may bring about a condensed memory of pleasurable interactions with mother, linking oral and anal libidinal developments. In contrast, enraged reaction to frustrations during the oral period and power struggles during the anal period may link consonant aggressive affect states, thus integrating the aggressive drive. Further, the infant's intense positive affective investment of mother during the practicing stage of separation-individuation may later link up with a sexually imbued longing for her derived from the activation of genital feelings in the oedipal stage of development. In general, the affects of sexual excitement and rage may be considered, respectively, as the central organizing affects of libido and aggression.

If we consider affects the primary psychobiological building blocks of drives and the earliest motivational systems, we still have to explain how affects become organized into supraordinate hierarchical drive systems. Why not say that the primary affects themselves are the motivational systems? In my view, a multitude of complex secondary combinations and transformations of affects exists, so that a theory of motivation based on affects rather than on two basic drives would be complex and clinically unsatisfactory. I also believe that the unconscious organization and integration of affectively determined early experience assumes a higher level

of motivational organization than that represented by affect states per se. We need to assume a motivational organization that does justice to the complex integration of all affective developments in relation to the parental objects.

An effort to replace both drive and affect theory with an attachment theory or an object relations theory that rejects the concepts of drives leads to a simplification of intrapsychic life by stressing only the positive or libidinal elements of attachment and neglecting the unconscious organization of aggression. Although in theory this should not necessarily be so, in practice those object relations theoreticians who have rejected drive theory have, in my view, also seriously neglected the motivational aspects of aggression.

AFFECT AND INTRAPSYCHIC FORCES

For all these reasons, I think we should not replace a drive theory by an affect theory or an object relations theory of motivation. It seems eminently reasonable to me to consider affects the link between biologically determined instinctive components, on the one hand, and intrapsychic organization of the overall drives, on the other. The correspondence of the series of rewarding and aversive affect states with the dual lines of libido and aggression makes sense from both clinical and theoretical perspectives.

The concept of affects as the building blocks of drives I believe, resolves some persistent problems in the psychoanalytic theory of drives. It broadens the concept of erotogenic zones as the source of libido into a general consideration of all physiologically activated functions and bodily zones that become involved in affectively invested interactions of the infant and child with mother. These functions include the shift from concerns with bodily functions to concerns with social functions and role enactments. My proposed concept also provides the missing links within psychoanalytic theory among the "sources" of aggressively invested infant-mother interactions, the "zonal" function of aggressive rejection of oral ingestion, anal control, direct physical power struggles linked with temper tantrums, and the like. I am suggesting that it is affectively invested object relations that energizes physiological "zones."

The id, according to this concept of the relation between drives and affects, consists of repressed, intensely aggressive or sexualized internalized object relations. The condensation and displacement characteristic of the contents of the id reflect the linkage of affectively imbued self and object representations with a similar positive or negative valence,

thus constituting the corresponding aggressive, libidinal, and, later on, combined series.

My proposal permits us to do justice to the biologically determined input of new affective experiences throughout life. These experiences include the activation of intense sexual excitement during adolescence, when erotically tinged affect states become integrated with the genital excitement and with erotically charged emotions and fantasies derived from the oedipal stage of development. In other words, the intensification of drives (both libidinal and aggressive) at various stages of life is determined by the incorporation of new psychophysiologically activated affect states into preexistent, hierarchically organized affect systems.

More generally, once the organization of drives has been consolidated as the supraordinate hierarchical motivational system, any particular activation of drives in the context of intrapsychic conflict is represented by the activation of a corresponding affect state. This affect state includes an internalized object relation, basically a particular self representation relating to a particular object representation under the impact of a particular affect. The reciprocal role relation of self and object that is framed by the affect is usually expressed as a concrete fantasy or wish. Affects, in short, become the signals or representatives of drives as well as their building blocks.

This view of affects, while in contrast to Freud's second theory of affects, is in consonance with his first and third theories: with the first theory, in linking affects and drives; with the third theory, in stressing the inborn disposition to affects that characterizes the original ego-id matrix.

AFFECTS IN THE PSYCHOANALYTIC SITUATION

Having described a theory of drive development, I return to the clinical manifestations of affects to support Brierley's and Jacobson's suggestions that clinically we always work with affects or emotions and that affects are complex intrapsychic structures rather than simply discharge processes.

The psychoanalytic situation provides a unique way of exploring all kinds of affects—from primitive (such as rage or sexual excitement) to cognitively differentiated, compounded ones. As Brierley (1937) and Jacobson (1953) pointed out, affects include a basic subjectively pleasurable or painful experience. The subjective experiences of pleasure and pain are usually but not always differentiated from each other.

Affects differ quantitatively as well as qualitatively: the intensity of subjective experiences varies, as is usually observable in physiological

discharge patterns and/or psychomotor behavior. The patient's behavior also serves to communicate his subjective experience to the analyst. Indeed, the communicative functions of affects are central to the transference and permit the analyst to empathize with and (internally) respond emotionally to the patient's experience. The ideational content of affects is important in relation to the psychoanalytic exploration of all affects, particularly primitive ones, which may give the initial impression of being almost devoid of cognitive content. Psychoanalytic exploration of intense affect storms in regressed patients, in my experience, consistently demonstrates that there is no such thing as a "pure" affect without cognitive content.

The affects we observe in the psychoanalytic situation not only always have cognitive content but—and this is, I think, a crucial finding—always have an object relations aspect as well; that is, they express a relation between an aspect of the patient's self and an aspect of one or another of his object representations. Furthermore, affect in the psychoanalytic situation either reflects or complements a reactivated internal object relation. In the transference, an affect state recapitulates the patient's significant past object relation. Indeed, all actualizations of an object relation in the transference contain a certain affect state as well.

DEFENSIVE DISTORTIONS

The manifestations of impulse/defense configurations in the psychoanalytic situation may be conceptualized as the activation of certain object relations in conflict. One side of the configuration is defensive; the other reflects the impulse or drive-derivative side. The masochistic suffering of a hysterical patient who experiences the analyst as frustrating and punitive may serve as a defense against the patient's underlying sexual excitement, fantasies, and positive oedipal strivings: the mixture of sorrow, rage, and self-pity may reflect an affect state with defensive functions directed against repressed sexual excitement. In fact, whenever, clinically speaking, we point to the defensive use of one drive against another, we are actually referring to the defensive function of one affect against another.

The defensive process itself, however, frequently disrupts the affect state. For example, the patient may repress the cognitive aspects of the affect, its subjective experience, or everything except its psychomotor aspects. When the affect state is disrupted, the predominant object relation in the transference is interfered with, and the patient's full awareness of his own subjective experience is obscured. The analyst's capacity

for empathic understanding is also thereby thwarted. Consider, for example, listening to an obsessive patient's sexual thoughts without their affective, sexually excited qualities, which remain in repression; or to a hysterical patient's intense and dramatic affect storm, which obscures the cognitive content of the experience; or to a narcissistic patient's speaking in what sounds like highly emotional tones while his total behavior conveys the absence or unavailability of any emotional communication. This dissociation of various components of affects in the service of defense may give the impression that the subjective experience of affects is separate from their cognitive, behavioral, communicative aspects, particularly in the initial stages of treatment or when resistance is strong.

This defensive dissociation seems to illustrate the traditional psychological view that affect, perception, cognition, and action are separate ego functions. But when these defensive operations are worked through, and as the deeper layers of the patient's intrapsychic experience gradually emerge, the psychoanalyst encounters the integration of the various components of the affects. When the nature of the unconscious conflict that develops in the transference is on the primitive side, then the affects appear full-blown and centered upon a subjective experience, but with a full complement of cognitive, physiological, behavioral, and communicative aspects, and expressing a specific relation between the patient's self and the corresponding object representation in the transference.

These observations confirm recent neuropsychological research on affects, which contradicts the traditional idea that affects, cognition, communicative behavior, and object relations develop separately (Emde et al. 1978; Hoffman 1978; Izard 1978; Plutchik 1980; Plutchik and Kellerman 1983; Stern 1985; Emde 1987). Affects thus can be seen as complex psychic structures indissolubly linked to the individual's cognitive appraisals of his immediate situation and containing a positive or negative valence with regard to the relation of the subject to the object of the particular experience. Affects, therefore, because of this cognitive appraisal component, have a motivational aspect.

Arnold's (1970a, 1970b) definition of emotions—that they are a felt action tendency based on appraisal—is relevant here. "Emotion" in this context corresponds to what I refer to as "affect." (As I said earlier in this chapter, I prefer to reserve the term *emotion* for affects with highly differentiated cognitive contents and relatively mild or moderate psychomotor and/or neurovegetative components.) Arnold described two constituents of emotion: one static, the appraisal; and one dynamic, the impulse

toward what is appraised as good or away from what is appraised as bad. If Arnold's work reflects a general trend of contemporary neuropsychological research on affects, as I believe it does, this trend is remarkably concordant with the clinical findings on affects in the psychoanalytic situation as spelled out by Brierley (1937) and Jacobson (1953).

THE ORIGINS OF FANTASY AND PEAK-AFFECT STATES

When intense affect states are activated in the transference, a corresponding gratifying or frustrating past object relation is recalled, together with the effort to reactivate that object relation if it was gratifying or escape from it if it was painful. This process of juxtaposition, in fact, illustrates the origin of fantasy—namely, the juxtaposition of an evoked remembered state with a future desired state in the context of a current perception that activates the desire for change. The formation of fantasy thus reflects the simultaneity of past, present, and future that is characteristic of the id, predating the awareness and acceptance of objective space-time constraints that characterize the differentiated ego (Jaques 1982).

From a primordial integration of primitive affective memory linking "all-good" or "all-bad" peak-affect states stems the development of specific wishful fantasies linking self and object that characterize unconscious fantasy. Peak-affect states occur in connection with highly desirable (pleasurable) or undesirable (painful) experiences that motivate intense desires to respectively reinstate or avoid similar affective experiences. These desires, expressed as concrete unconscious wishes, constitute the motivational repertoire of the id. "Desire" expresses a more general motivational urge than "wish": we might say that unconscious desire is expressed in concrete wishes. Unconscious fantasy centers around wishes that concretely express desire and ultimately the drives.

Peak-affect experiences may facilitate the internalization of primitive object relations organized along the axis of rewarding, or all-good, or aversive, or all-bad, ones. In other words, the experience of self and object when the infant is in a peak-affect state acquires an intensity that facilitates the laying down of affective memory structures. Originally, in these internalizations, self and object representations are not yet differentiated from each other. Fused, undifferentiated, or condensed all-good self and object representations are built up separately from equally fused, undifferentiated, or condensed all-bad self and object representations. These earliest intrapsychic structures of the symbiotic stage of development (Mahler and Furer 1968) would correspond both to the beginning of structure formation of internalized object relations and to the beginning

of overall organization of libidinal and aggressive drives. At the same time, the internalization of object relations represents the origin of the tripartite structure as well: internalized object relations and their corresponding affective investment constitute the substructure of the ego, the id, and the superego. I see the structural characteristics associated with the id as based on a combination of several factors: the primitive, diffuse, and overwhelming nature of early affective memory derived from peak affects and the corresponding internalized object relations; the undifferentiated quality of early subjectivity and early consciousness; and the rudimentary nature of symbolic functions in the process of condensation of past, present, and evoked "future" in early fantasy formation.

Affect states may have very different developmental consequences. Modulated affect states may contribute directly to ego development. Parallel mother-infant interaction and learning under conditions of mild or modulated affect states might set up memory structures reflecting more discriminatory and instrumental relations to the immediate psychosocial environment.

AFFECTS AND EARLY SUBJECTIVE EXPERIENCE

What evidence do we have affirming the fact that infants display of affects means that they have a subjective awareness of pain or pleasure? This question implicitly argues against early subjectivity, early intrapsychic experience before the development of linguistic capacities, and early activation of intrapsychic motivational systems. The study of tension states in infants following the presentation of stimuli that activate affects (as, for example, in the study of heart rate) indicates modification in tension—either increase or decrease, according to the cognitive implications of the stimuli. In other words, we are beginning to find evidence of an increase or decrease in intrapsychic tension prior to the time when the expressive and discharge patterns of affect become apparent (Sroufe 1979; Sroufe et al. 1974).

There is also evidence that the diencephalic centers that mediate the experience of aversive or rewarding qualities of perception are fully mature at birth, which supports the assumption of an early capacity for experiencing pleasure and pain. In addition is the surprisingly early infant capacity for cognitive differentiation, suggesting the potential for affective differentiations as well. It seems reasonable to assume that a three-month-old is able to experience emotions as well as show behavioral evidence of pleasure, rage, or disappointment (Izard 1978), a point developed at great length by Plutchik and Kellerman (1983).

Recent advances in the observations of infant-mother interactions (Stern 1977, 1985) point to the activation, within the first few weeks of life, of a capacity for discrimination of properties belonging to mother, indicating that the infant is "prewired" to begin to form distinct schemas of self and of others. The cognitive potential of infants, in other words, is much more sophisticated than has traditionally been assumed, and the same is true of the infant's affective behavior.

Affective behavior strongly influences the infant's relation with mother from birth on (Izard 1978; Izard and Buechler 1979). A central biological function of inborn affective patterns—with their behavioral, communicative, and psychophysiological manifestations—is to signal the infant's needs to the environment (the mothering person) and thus to initiate the communication between the infant and mother that marks the beginning of intrapsychic life (Emde et al. 1978). Recent research has surprised us by describing a high degree of differentiation in infant-mother communications from very early on (Hoffman 1978). Neuropsychological theorizing now assumes that affective memory is stored in the limbic cortex; as direct brain-stimulation experiments indicate, this permits the reactivation of not only the cognitive aspects of past experience but also the affective aspects, particularly the subjective, affective coloring of that experience (Arnold 1970a). I have proposed earlier that affects, operating as the earliest motivational system, are intimately linked with the fixation by memory of an internalized world of object relations (Kernberg 1976).

Insofar as current neuropsychological theorizing about the nature of affects implies that their subjective quality—basically, pleasure and pain—is a central feature that integrates their psychophysiological, behavioral, and communicative aspects, and as highly differentiated behavioral, communicative, and psychophysiological aspects of affects are observable from the first weeks of life, it seems reasonable to assume that the capacity for subjective experience of pleasure and pain exists very early on. In fact, granting that affective schemas as well as perceptual and motor schemas are operant from birth on, the subjective experience of pleasure and pain (subjectivity) can be assumed to constitute the first stage of consciousness and, by that token, the first stage of development of the self as well.

Piaget's statements that "affective states that have no cognitive elements are never seen, nor are behaviors found that are wholly cognitive" and that "affectivity would play the role of an energy source on which the functioning but not the structures of intelligence would depend" (1954, p. 5) probably reflect generally accepted principles of psychological func-

tioning. I have suggested earlier in this chapter that affective subjectivity, the primordial experience of self, helps to integrate—in the form of affective memory—perceptual, behavioral, and interactional experiences, as well as the affective schemata themselves, particularly when the infant is in an extremely pleasurable or unpleasurable affective state (peak-affect state), which maximizes his alertness and attention.

It would also seem reasonable to assume that such an assembly of memory structures during peak-affect states may spur the earliest symbolic activities, in that one element of such peak-affective constellations stands for the entire constellation. A light turned on in a room, for example, represents the presence of the feeding mother even before she herself is perceived. One could argue about the point at which simple association and conditioned reflexes are transformed into symbolic thinking—in the sense that one element stands for an entire constellation of evoked experience outside the rigid linkage of conditioned associations—but, in any case, it seems reasonable to assume that the earliest symbolic function, an active representation of an entire sequence by one of its elements, placed outside the rigid associative chain, would occur under precisely such conditions.

Peak-affect states, then, would constitute the conditions under which purely affective subjectivity would be transformed into mental activity with symbolic functions, clinically represented by affectively imbued memory structures of pleasurable relations of infant and mother, in which self and object representations, in spite of their highly differentiated, cognitive inborn schemata, are as yet undifferentiated. Affective memory structures derived from the unpleasurable or painful peak-affect states in which self and object representations are also undifferentiated would be built up separately.

Memory structures acquired during peak-affect states will be very different from those acquired during quiescent or low-level affect states. When the infant is in the latter state, the memory structures established will be largely of a cognitive, discriminatory nature and will contribute directly to ego development. Ordinary learning thus occurs under conditions in which alertness is focused on the immediate situation and tasks, with little distortion derived from affective arousal and no particular defense mechanism interfering with it. These memory structures constitute the early precursors, we might say, of more specialized and adaptive ego functioning—the "primary autonomy" structures of early consciousness, which are gradually integrated into the affective memory structures and also contribute to the later stages of integration of total consciousness.

In contrast, peak-affect experiences facilitate the internalization of primitive object relations organized along the axes of rewarding, or all-good, and aversive, or all-bad, objects. The experiences of self and object under the impact of extreme affect activation acquire an intensity that facilitates the laying down of affectively impregnated memory structures. These affective memory structures, constituted in essence of self and object representations in the context of a specific peak-affect experience, represent the earliest intrapsychic structures of the symbiotic stage of development (Mahler and Furer 1968). They mark the beginning of internalized object relations as well as of the organization of libidinal and aggressive drives.

I am thus proposing a first stage of consciousness characterized by peak-affect states and the beginning of symbolization. This early stage has essentially subjective features and cannot be considered equivalent to the data indicating the early capacity for cross-model differentiation, which presumably corresponds to prewired potentials optimally observable under experimental conditions characterized by mild or modulated affect dispositions. Subjectivity implies experiencing, and experiencing should logically be maximal under conditions of peak affects. Subjectivity also implies thinking and therefore requires, as a minimum, the manipulation of symbols. That minimum, I propose, implies a breaking out from the rigid chain of conditioned associations.

Perhaps of particular importance here is the gradual development of two parallel series of all-good and all-bad fantasied characteristics of this symbiotic world: the pleasure connected with the presence of the "good" feeding mother is in sharp contrast to the pain related to the "bad" mother when the infant is frustrated, discomfited, or enraged. By the same token, the transformation of painful experiences into the symbolic image of an undifferentiated "bad self–bad mother" obviously contains an element of fantasy that transcends the realistic character of the "good" self-object representations. The original fantasy material of what later becomes the repressed unconscious may reflect a predominance of aggressive imagery and affects.

Subjective experience in peak-affect states may initiate the construction of an internal world that gradually separates out into a deep layer of fantastic imagery linked to internalized object relations acquired during the peak states and a more superficial layer that "infiltrates" the cognitively more realistic perceptions of external reality built up under ordinary states of low-level affect when the infant is in alert exploration of the surround. Eventually, symbol formation and affective organization of reality would develop in this surface layer of perception as well, trans-

forming wired-in organization of perception into symbolically manipulated information: that is, "conscious thinking," the origin of secondary-process thinking, evolves on the surface of the deep layer.

The dynamic unconscious originally includes unacceptable states of self-awareness under the influence of aggressively invested relations with object representations similarly perceived by means of primitive defensive operations, particularly projective identification. The early peak-affect states resulting from frustration activate primitive fantasies of frustrating "objects" represented by sensoriperceptive experiences that also come to symbolize efforts to "expel" such intolerable objects and rageful wishes to destroy them, together with transformation of the experience of frustration into the fantasy of being attacked and endangered. The repression of peak-affect experiences of a pleasurable nature—particularly of sexually excited states related to unacceptable fantasies involving parental objects—follows the earlier aggressive wishes and fantasies of the dynamic unconscious. The unconscious defenses connected with primitive fantasies and the later defenses that secondarily reinforce repression eventually "encapsulate" the deepest, unconscious layer of aggressively and libidinally invested object relations—the id.

Insofar as the earliest pleasurable peak-affect experiences of an undifferentiated self and object representation under the condition of an all-good object relation may be considered a core self experience, the awareness of self and of others is intimately linked in the area of self experience that will be incorporated into ego functions and structure as well. Although affectively modulated experiences may foster the mapping out of areas of differentiation between self and objects from early on, a core of fused or undifferentiated primitive experiences is rooted in the early ego as well as in the id.

Peak-affect experiences thus give birth to a core structure of intersubjectivity, both in the earliest identification with an object of love (an "introjective identification") and in the earliest identification with an object of hatred at the "periphery" of self experience (a "projective identification"), which is later dissociated, projected more effectively, and eventually repressed.

Intersubjectivity, whether incorporated in the self experience or rejected by projective mechanisms, is therefore an inseparable aspect of the development of normal identity. The psychoanalyst, too, by means of "concordant identification"—that is, empathy with the patient's central subjective experience—and "complementary identification"—that is, empathy with what the patient cannot tolerate within himself and activates by means of projective identification—may diagnose the patient's world of internalized object relations, which is part of his ego identity.

The subjective experience of the self, with its component aspects of self-awareness or self-reflection, its sense of subjective continuity cross-sectionally and longitudinally, and its sense of responsibility for its actions, is more than a subjective fantasy. It constitutes an intrapsychic structure, a dynamically determined, internally consistent, stable frame for organizing psychic experience and behavioral control. It is a channel for various psychic functions that actualizes itself in these functions, a substructure of the ego that gradually acquires supraordinate functions within the ego. It represents an intrapsychic structure of the highest order, whose nature is confirmed by its behavioral consequences, its expression in character formations, and its human depth and moral commitment in relations with others.

Defenses push the dynamic unconscious deeper and deeper into the psychic apparatus, a development that culminates with the establishment of repressive barriers that simultaneously signify the mutual rejection and the consolidation of the id and the ego. The dynamic unconscious of the neurotic patient and of the normal person is the end-product of a long evolution of psychic functioning, within which the qualities of consciousness and the dynamic unconscious are more closely interwoven than one might think on the basis of observation. But the eruption of the dynamic unconscious into consciousness is not reserved to patients with severe character pathology or psychoses. Interpersonal behavior in small unstructured groups, and to an even greater extent in large unstructured groups that temporarily eliminate or blur ordinary social role functions, may activate, sometimes in frightening ways, primitive contents of the repressed in the form of fantasies and behaviors shared by the entire group. This leads to the question of the ultimate nature of the motivational forces of the dynamic unconscious and to the psychoanalytic theory of drives.

ORIGIN AND STRUCTURE OF DRIVES AS MOTIVATIONAL FORCES

In my view, affects are the primary motivational system in that they are at the center of each of the infinite number of gratifying and frustrating concrete experiences the infant has with his environment. Affects link the series of undifferentiated self/object representations so that gradually a complex world of internalized object relations, some pleasurably tinged, others unpleasurably tinged, is constructed. But even while affects are linking internalized object relations in two parallel series of

gratifying and frustrating experiences, "good" and "bad" internalized object relations are themselves being transformed. The predominant affect of love or hate of the two series of internalized object relations is enriched and modulated and becomes increasingly complex.

Eventually, the internal relation of the infant to the mother under the sign of "love" is more than the sum of a finite number of concrete loving affect states. The same holds true for hate. Love and hate thus become stable intrapsychic structures in the sense of two dynamically determined, internally consistent, stable frames for organizing psychic experience and behavioral control in genetic continuity through various developmental stages. By that very continuity, they consolidate into libido and aggression. Libido and aggression, in turn, become hierarchically supraordinate motivational systems, expressed in a multitude of differentiated affect dispositions under different circumstances. Affects are the building blocks, or constituents, of drives; they eventually acquire a signal function for the activation of drives.

Again, it needs to be stressed that drives are manifest not simply by affects but by the activation of a specific object relation, which includes an affect and in which the drive is represented by a specific desire or wish. Unconscious fantasy, the most important being oedipal in nature, includes a specific wish directed toward an object. The wish derives from the drive and is more precise than the affect state—an additional reason for rejecting a concept that would make affects rather than drives the hierarchically supraordinate motivational system.

Chapter 2 THE PSYCHOPATHOLOGY OF HATRED

Having offered a general theory of affects as the compo-nent substructures of drives, I turn now to a specific affect that occupies a central position in human behavior. I am referring to hatred, the core affect of severe psychopathological conditions, particularly severe personality disorders, perversions, and functional psychoses. Hatred derives from rage, the primary affect around which the drive of aggression clusters; in severe psychopathology, hatred may evolve into an overwhelming dominance directed against the self as well as against others. It is a complex affect that may become the major component of the aggressive drive, overshadowing other universally present aggressive affects such as envy or disgust.

In what follows, I focus for the most part on the developmental vicissitudes of rage, which lead to the dominance of hatred in certain patients with severe character pathology, resulting in the emergence of hatred as an overriding affect in the transference. This development permits the psychoanalytic exploration of hatred, but it also presents formidable challenges to the analyst, who must resolve the corresponding psychopathology in the transference. The formulations that follow are based, on the one hand, on the relation between the pathology of mother-infant relationships in infants at high risk and the development of inordinate aggression in such infants (Massie 1977; Gaensbauer and Sands 1979; Call 1980; Roiphe and Galenson 1981; Fraiberg 1983; Galenson 1986; Osofsky 1988) and, on the other hand, on the psychopathology of excessive aggression in the transference in patients with borderline personality organization and narcissistic and antisocial personality disorders (Winnicott 1949; Bion

1957a, 1959, 1970; A. Green 1977; Moser 1978; Ogden 1979; Krause 1988; Krause and Lutolf 1988; Grossman 1991). Observations of extreme regression in patients who show a predominance of hatred in the transference constitute the principal source for the formulations that follow.

RAGE

Clinically, the basic affect state characterizing the activation of aggression in the transference is that of rage. Irritation is a mild aggressive affect that signals the potential for rage reactions and, in chronic form, presents as irritability. Anger is a more intense affect than irritation, usually more differentiated in its cognitive content and in the nature of the object relationship that is activated. A full-fledged rage reaction—its overwhelming nature, its diffuseness, its "blurring" of specific cognitive contents and corresponding object relations—may convey the erroneous idea that rage is a "pure" primitive affect. Clinically, however, the analysis of rage reactions—as of other intense affect states—always reveals an underlying conscious or unconscious fantasy that includes a specific relation between an aspect of the self and an aspect of a significant other.

Infant research documents the early appearance of rage as an affect and its primordial function: to eliminate a source of pain or irritation. A later developmental function of rage is to eliminate an obstacle to gratification; the original biological function of rage—signaling to the caregiver to facilitate elimination of an irritant—now becomes a more focused appeal to the caregiver to restore a desired state of gratification. In the unconscious fantasies that develop around rage reactions, rage comes to signify both activation of an all-bad object relation and the wish to eliminate it and restore an all-good one. At a still later developmental stage, rage reactions may function as last-ditch efforts to restore a sense of autonomy in the face of highly frustrating situations unconsciously perceived as the threatening activation of all-bad, persecutory object relationships. A violent assertion of will functions to restore a state of narcissistic equilibrium; this act of self-assertion represents an unconscious identification with an idealized—all-good—object.

Clinically, the intensity of the aggressive affects—whether irritation, anger, or rage—correlates roughly with their psychological function: to assert autonomy, to eliminate an obstacle or barrier to a desired degree of satisfaction, or to eliminate or destroy a source of profound pain or frustration. But the psychopathology of aggression is not limited to the intensity and frequency of rage attacks. The most severe and dominant of the affects that together constitute aggression as a drive is the complex or

elaborated affect of hatred. As we move from the transference developments of patients with neurotic personality organization to those of patients with borderline personality organization, particularly those with severe narcissistic pathology and antisocial features, we are increasingly faced not only with rage attacks in the transference but with hatred, which emerges along with certain typical secondary characterological expressions of and defenses against awareness of this affect.

HATRED

Hatred is a complex aggressive affect. In contrast to the acuteness of rage reactions and the easily varying cognitive aspects of anger and rage, the cognitive aspect of hatred is chronic and stable. Hatred also presents with characterological anchoring that includes powerful rationalizations and corresponding distortions of ego and superego functioning. The primary aim of one consumed by hatred is to destroy its object, a specific object of unconscious fantasy, and this object's conscious derivatives; the object is at bottom both needed and desired, and its destruction is equally needed and desired. Understanding this paradox is at the center of the psychoanalytic investigation of this affect. Hatred is not always pathological: as a response to an objective, real danger of physical or psychological destruction, a threat to the survival of oneself and those one loves, hatred is a normal elaboration of rage aimed to eliminate that danger. But unconscious motivations usually enter and intensify hatred, as in the search for revenge. When it is a chronic characterological predisposition, hatred always reflects the psychopathology of aggression.

An extreme form of hatred demands the physical elimination of the object and may be expressed in murder or in a radical devaluation of the object that may generalize in the form of a symbolic destruction of all objects—that is, all potential relationships with significant others—as is clinically observable in antisocial personality structures. This form of hatred is sometimes expressed in suicide, where the self is identified with the hated object and self-elimination is the only way to destroy the object as well.

Clinically, some patients with the syndrome of malignant narcissism (narcissistic personality, ego-syntonic aggression, paranoid and antisocial tendencies) and "psychopathic" transferences (deceptiveness as a dominant transference feature) may consistently attempt to exploit, destroy, symbolically castrate, or dehumanize significant others—including the therapist—to an extent that defies the therapist's efforts to protect or recapture some island of an idealized primitive, all-good object

relationship. At the same time, the transference may appear to be remarkably free from overt aggression; chronic deceptiveness and the search for a primitive all-good self state that eliminates all objects—by means of alcohol or drugs, for example, and by unconscious and conscious efforts to coopt the therapist in the exploitation or destruction of others—dominate the scene. The therapist's efforts to stand up against this diffuse, generalized destruction or corruption of everything valuable may be experienced by the patient (by projective mechanisms) as a brutal attack, which leads to the emergence of direct rage and hatred in the transference; we witness the transformation of a "psychopathic" into a "paranoid" transference (see chap. 14). Paradoxically, this transformation offers a glimmer of hope for these patients.

A less severe degree of hatred is expressed in sadistic tendencies and wishes; the patient has an unconscious or conscious desire to make the object suffer, with a sense of profound conscious or unconscious enjoyment of that suffering. Sadism may take the form of a sexual perversion with actual physical damaging of the object, or it may be part of the syndrome of malignant narcissism, sadomasochistic personality structure, or, sometimes, a rationalized, intellectualized form of cruelty that includes wishes to humiliate the object. In contrast to the earlier, more encompassing form of hatred, sadism is characterized by the wish not to eliminate but to maintain the relationship with the hated object in an enactment of an object relationship between a sadistic agent and a paralyzed victim. The desire to inflict pain and pleasure in doing so are central here, representing an implicit condensation of aggression and libidinal excitement in inducing such suffering.

A still milder form of hatred centers around the desire to dominate the object, a search for power over it that may include sadistic components but in which attacks on the object tend to be self-limited by the object's submission and its implied reconfirmation of the subject's freedom and autonomy. Anal-sadistic components predominate over the more primitive oral-aggressive ones found in the more severe forms of hatred; the assertion of hierarchical superiority and "territoriality" in social interactions and the aggressive aspects of regressive small- and large-group processes are the most frequent manifestations of this milder level of hatred.

Finally, in those with relatively normal superego integration and a neurotic personality organization with a well-differentiated tripartite structure, hatred may take the form of a rationalized identification with a strict and punitive superego, the aggressive assertion of idiosyncratic but well-rationalized systems of morality, justified indignation, and primitive levels of commitment to vindictive ideologies. Hatred at this level, of course, bridges over to the sublimatory function of courageous aggressive assertion in the service of commitment to ideals and ethical systems.

At this level of integration there is usually also a tendency toward self-directed hatred in the form of cruelty of the superego; clinically we see a potential for a transformation of transferences from the primitive "paranoid" into the more advanced "depressive" type. Masochistic and sadomasochistic personality structures and mixed neurotic constellations including paranoid, masochistic, and sadistic traits may experience relatively sudden shifts between depressive and paranoid transference regression. In contrast, at more severe levels of psychopathology, the transference is overwhelmingly paranoid, except when psychopathic transferences defend the patient against the paranoid ones.

The entire spectrum of affective and characterological components of hatred may be observed in the transference of patients of the second level of pathology, patients who have at least a wish to preserve the hated object. The chronicity, stability, and characterological anchoring of hatred is matched by the desire to inflict pain upon the object, characterological—and sometimes sexual—sadism, and cruelty.

Primitive hatred also takes the form of an effort to destroy the potential for a gratifying human relationship and for learning something of value in that human interaction (see chap. 13). Underlying this need to destroy reality and communication in intimate relationships is, I believe, unconscious and conscious envy of the object, particularly of an object not dominated from within by similar hatred.

It was Melanie Klein (1957) who first pointed to envy of the good object as a significant characteristic of patients with severe narcissistic psychopathology. Such envy is complicated by the patient's need to destroy his own awareness of it, lest his terror over the savagery of his hatred of what, *au fond*, he values in the object be exposed. Behind the envy of the object and the need to destroy and spoil anything good that might come from contacts with it lies unconscious identification with the originally hated—and needed—object. Envy may be considered both a source of a primitive form of hatred, intimately linked with oral aggression, greed, and voracity, and a complication of the hatred that derives from the fixation to trauma.

At the surface, hatred of the unconsciously—and consciously—envied object is usually rationalized as fear of the object's destructive potential, deriving both from actual aggression inflicted by essentially needed objects in the patient's past (in patients who have been severely traumatized) and from projection of his own rage and hatred.

Tendencies toward chronic and potentially severe self-mutilation and

nondepressive suicidal behaviors frequently accompany the syndrome of malignant narcissism. Self-mutilation typically reflects unconscious identification with a hateful and hated object. Hatred and the inability to tolerate communication with the object may protect the patient from what might otherwise emerge as a combination of cruel attacks on the object, paranoid fears of that object, and self-directed aggression in identification with the object.

Clinically, the transference characterized by arrogance, curiosity, and pseudostupidity (incapacity to reflect on what the therapist says), described by Bion (1957a), illustrates the patient's acting out of envy of the therapist, destruction of meaning, and sadism.

One of the most consistent features in transferences dominated by acting out deep hatred is the patient's extraordinary dependence on the therapist, manifested simultaneously with aggression toward the therapist—an impressive demonstration of "fixation to the trauma." At the same time, the patient's fantasies and fears reflect his assumption that unless he consistently fights off the therapist, he will be subjected to a similar onslaught of hatred and sadistic exploitation and persecution from the therapist. Obviously, by means of projective identification, the patient is attributing his own hatred and sadism to the therapist; the situation illustrates the intimate link between persecutor and persecuted, master and slave, sadist and masochist, all referring in the last resort to the sadistic, frustrating, teasing mother and the helpless, paralyzed infant.

Basically, the patient is enacting an object relation between persecutor and victim, alternating these roles in his identifications while projecting the reciprocal role onto the therapist. In the most pathological cases, it is as if the only alternative to being victimized is to become a tyrant, and the repeated assertions of hatred and sadism would appear to be the only form of survival and meaning, aside from murder, suicide, or psychopathy. In milder cases, an additional dynamic factor, envy, emerges—intolerance of the good object who escapes from that savagery and who is hated for willfully withholding (as the patient fantasizes) what could transform the object from a persecuting one into an ideal one. Here the search for an ideal object (an ideal mother) lies behind the unending onslaught of hatred in the transference.

In still milder cases, with more sophisticated and elaborated types of sadomasochistic behavior within a neurotic personality organization, we discover the unconscious potential for pleasure in pain, the temptation to experience pain as a precondition for experiencing pleasure, in the context of castration anxiety, unconscious guilt over oedipal strivings,

and as the ultimate transformation of passively experienced pain into an active compromise solution of the corresponding unconscious conflicts.

All these dynamics may emerge intimately condensed and combined, with differences in degree and proportion. What they have in common is the intense motivation to maintain a link with the hated object, a link that gratifies these various primitive transferences and is, in my view, responsible for the powerful fixation to this traumatic relationship.

FIXATION TO THE TRAUMA

I believe that peak-affect states organize internalized object relationships not only under conditions of love—the elation that corresponds to a primitive idealized fusion between an all-good self and an all-good object—but also under conditions of rage, in the internalization of originally undifferentiated all-bad self and object representations, which are gradually sorted out into the typical object relation under the domination of hatred. A powerful link to the traumatizing object under the dominance of hatred has been observed in studies of battered children and of infants at high risk, and also in studies of persons in extremely traumatic circumstances, such as hijacked airplane passengers who end up defending their captors (the "Stockholm Syndrome"). Research by Fraiberg (1983) and Galenson (1986) is particularly instructive regarding infants' internalization of the aggressive behavior of the mother toward them and their replication of the mother's behavior in relationship with her and with other objects.

Intense attachment to the frustrating mother is the ultimate origin of the transformation of rage into hatred. The cause of this transformation is the fixation to a traumatic relationship with a fundamentally needed object that is experienced as all-bad and as having destroyed or swallowed up the ideal, all-good object. The revengeful destruction of this bad object is intended to magically restore the all-good one, but in the process it leads to the destruction of the very capacity of the self to relate to the object. This transformation takes the form of identifying not simply with the object (mother) but with the *relationship* to her, so that the hatred of mother as victimizer, with its painful, impotent, paralyzing implications, also is transformed into identification with her as the cruel, omnipotent, destructive object. At the same time a search develops for other objects onto whom the attacked, depreciated, and mistreated self can be projected. In identifying with both suffering self and sadistic object, the subject is himself swallowed up by the all-encompassing aggression in the relationship.

Hatred as a reversal of suffering is a basic type of revengeful triumph over the object, a triumph also over the terrifying self representation achieved by projective identification, and symbolic revenge for past suffering condensed in the fixation to sadistic behavior patterns. Patients so motivated mistreat others sadistically because they experience themselves as being mistreated, again, by sadistic objects; unconsciously, they become their own persecutory objects while sadistically attacking their victims. They cannot escape being victim and perpetrator at the same time. As victimizer, they cannot live without their victim—the projected, disowned persecuted self; as victim, they remain attached to their persecutors internally and sometimes, in behavior shocking to an observer, externally as well.

Extremely contradictory, unreliable behaviors on the part of mother probably reinforce the psychopathic end of the spectrum of hatred by permitting the interpretation of her behavior as a betrayal by the potentially good object, which thus becomes unpredictably and overwhelmingly bad. Identification with a betraying object initiates the path to a revengeful destruction of all object relations. The ultimate source of the paranoid urge to betray (Jacobson 1971a, pp. 302–318) probably lies here. The most severely psychopathological attachment behavior has been described in infants whose mothers' behavior combined abandonment, violence, chaos, and a teasing overstimulation together with chronic frustration (Fraiberg 1983; Galenson 1986).

Elsewhere (Kernberg 1991b) I have described the inclusion of an aggressive component of sexual excitement—the aggressive implication of penetrating and being penetrated—as a means of incorporating aggression in the service of love, utilizing the erotogenic potential of the experience of pain as a crucial contributor to the gratifying fusion with the other in sexual excitement and orgasm. This normal capability for transforming pain into erotic excitement miscarries when severe aggression has characterized the mother-infant relationship and is probably a crucial bridge to the erotic excitement of inducing suffering in others, which consolidates the pleasurable characteristics of sadistic hatred. If, at the same time, as Braunschweig and Fain (1971, 1975) have suggested, the alternatingly erotically stimulating and withdrawing attitudes of mother toward her infant form the basis of his unconscious identification with a teasing mother as well as with being teased and in the process activate his own sexual excitement as a basic affect, then a mother whose behavior includes exaggerated teasing of the infant may orient his hatred particularly toward the sadomasochistic perversions.

More generally, to cause deep pain in the infant and small child leads

first to rage and then, by the identificatory and transformational mechanisms mentioned, to the development of hatred. Thus, as Grossman (1991) has proposed, pain may lead, by a series of intrapsychic transformations, to the intensification and psychopathology of aggression.

Excessive activation of aggression as a drive (to which characterologically fixated hatred contributes fundamentally) interferes with the normal integration of the mutually dissociated, all-good and all-bad internalized object relations at the conclusion of the developmental phase of separation-individuation and therefore with the initiation of object constancy and the advanced stage of oedipal development. In disrupting these processes, excessive aggression leads to fixation at a point when all-good and all-bad internalized object relations were not integrated, while self and object representations within each of these all-good and all-bad object relationships were differentiated from each other. These constitute the psychostructural conditions of borderline personality organization, characteristic of severe personality disorders in which preoedipal and oedipal aggression is dominant.

Under more favorable circumstances, integration of all-good and all-bad internalized object relations may proceed and object constancy may develop, leading to integration of the ego and superego structures and to the establishment of repressive boundaries separating ego from id: the tripartite structure consolidates.Under such conditions the pathological hatred is absorbed by the superego. The integration of early sadistic superego precursors with the preoedipal ego ideal, on the one hand, and of oedipal prohibitions and demands with those earlier superego structures, on the other, leads to sadistic superego demands, depressive-masochistic psychopathology, and secondarily rationalized characterological sadism correlated with the integration of cruel and sadistic ethical systems. Or perhaps various sexual pathologies, including perversions at a neurotic level of personality organization, may contain hatred as a relatively harmless, eroticized symptom.

The wish to humiliate is another manifestation of hatred potentially integrated into superego-mediated character features. An obsessive-compulsive patient needs to control and dominate others to feel protected against threatening outbreaks of aggressive rebelliousness and chaos in others—thus enacting his identification with a hated object and his projection of unacceptable, repressed, and projected aspects of his self at a relatively high level of psychic functioning. Fixation to specific hated objects can be seen along the entire spectrum of psychopathology and illustrates, sometimes almost in caricature, attachment to the enemy or persecutor. It says something about the common origins of the basic

affects of rage and sexual excitement in the symbiotic phase that the highest tendency for sustained mutual gaze exists under conditions of intense hatred and intense love.

SOME COMMENTS ABOUT TREATMENT

What follows are some general considerations regarding the treatment of patients with severe psychopathology of aggression, particularly intense hatred in the transference. Elsewhere (chap. 3), I point to the importance of interpreting consistently and in depth the nature of the unconscious fantasies implied in the activation of rage in the transference, particularly to the importance of interpreting secondary defenses against acknowledging the pleasurable aspects of rage. In considering the spectrum of the psychopathology of hatred, I would first stress the countertransference consequences of this affect.

I have pointed out in earlier work (1975, 1984) that the patient, particularly the narcissistic patient with antisocial features, hates most what he most needs to receive from the therapist: unwavering dedication to him. The patient also hates, because he envies it, the creativity contained in the therapist's efforts to gain understanding and to communicate this understanding to the patient. The analyst's sense of being exhausted, that his efforts are going to waste, his sense of the enormity of the patient's lack of gratitude, may result in a countertransference that tends to perpetuate or even obscure the patient's acting out of hatred and envy.

The therapist may attempt to escape from his discouragement by emotionally disconnecting from the patient. The restoration of the therapist's tranquillity may be at the cost of an internal surrender that, not surprisingly, the patient often perceives but easily tolerates because he rightly experiences it as the therapist's defeat. An uneasy equilibrium may ensue in which a surface friendliness obscures the "parasitic" (Bion 1970) nature of the therapeutic relationship.

Or the therapist may enter into collusion with the splitting process in the patient, facilitating the displacement of aggression elsewhere and fostering the creation of a pseudotherapeutic alliance that ensures a friendly surface relationship in the transference.

Another solution frequently adopted by the therapist is to absorb the patient's aggression, in full awareness of what is going on but without finding a way to transform this acting out into viable interpretations. This development, which amounts to a masochistic submission to the "impossible" patient, is sometimes engaged in quite consciously by a therapist who believes that with sufficient love most things can be cured.

The counterpart to such a masochistic submission to the patient is often the eventual acting out of aggression in the countertransference, either by dismissing the patient or by unconsciously provoking him to leave.

It is most likely, however, that the therapist, even the experienced therapist, will oscillate in his internal stance from day to day, from session to session, between efforts to resolve the activation of hatred in the transference analytically and giving up or withdrawing. These natural oscillations may actually reflect a reasonable compromise formation that permits the therapist to step back and evaluate the effects of his various interventions and gives him some breathing space before he returns to an active interpretive stance.

In all cases, I think it is extremely important to diagnose secondary defenses against hatred at the most pathological end of the spectrum of aggression in the transference—that is, the development of antisocial or psychopathic transferences. The patient's conscious or unconscious corruption of all relationships, particularly the therapeutic one, must be examined consistently, with the therapist fully aware that such an examination will probably shift the apparently "quiet" psychopathic transference relationship into a severely paranoid one and activate intense hatred in the transference. The therapist's normal superego functions, his being moral but not moralistic (E. Ticho, personal communication), will be experienced by patients with antisocial tendencies as devastating attacks and criticisms.

It is important to interpret the patient's paranoid reaction as part of the interpretation of the antisocial transferences. Such an interpretation might run as follows: "I am under the impression that, if I point out to you that I believe (such and such behavior) is an expression of your profound need to destroy (a certain relationship), you might interpret my comment as if I were attacking you rather than trying to help you understand what I consider a very important aspect of your difficulties at this time."

Once the transferences have shifted from a dominantly antisocial into a paranoid mode, the general technical approach to severe paranoid regression is indicated, the characteristics and management of which I discuss elsewhere (chap. 4). I want now only to stress the need to acknowledge openly to the patient who is convinced of a paranoid distortion of reality that the therapist sees that reality in a completely different way but respects the temporary incompatibility of his and the patient's perceptions of it: in other words, a "psychotic nucleus" is identified, circumscribed, and tolerated in the transference before any attempt is made to resolve it interpretively. It is usually only at advanced stages of the

treatment of patients with severe psychopathology that integration of idealized and persecutory internalized object relations can take place, with a corresponding shift of paranoid into depressive transferences—that is, the emergence in the patient of guilt feelings, concern over the dangerous effects of aggression, and wishes to repair the psychotherapeutic relationship.

Where the sadistic elements are particularly marked, it is important that the patient become aware of his pleasure in hatred, a subject I deal with extensively in chapter 3. This requires that the therapist be able to empathize with the pleasure implied in the patient's aggression. When power relations are the dominant issue in the transference and hatred is expressed as an inordinate need to assert power and autonomy, analysis of this aspect of the transference is usually facilitated by the fact that ordinary anal-sadistic components are involved and the therapist is dealing with the "healthier" end of the spectrum of psychopathology of aggression.

Again, the most difficult patients are those in whom intense aggression goes hand in hand with deep psychopathology of superego functioning, so that internal constraints against dangerous enactment of aggression are missing, and the therapist may be realistically afraid of unleashing destructive forces beyond the capacity of the treatment to contain them. This applies to some patients who present the syndrome of malignant narcissism and is probably a major reason that the antisocial personality proper is unapproachable by means of psychoanalytic modalities of treatment. It is important that the therapist have a reasonable sense of security that the analysis of powerful aggressive forces will not create new risks for the patient or others, including himself. A realistic assessment of this possibility and a realistic structuring of the treatment situation to protect patient, therapist, and others from inordinate and dangerous, potentially irreversible effects of the acting out of aggression are preconditions for successful work in this area.

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severely ill borderline and narcissistic patients. In the latter instances, no change can be expected before a regression in the transference develops that permits the reactivation of what may amount to a very early mother-child relationship, the development of a new capacity for tenderness that reinvests skin eroticism, the idealization of body parts, and the early roots of polymorphous perverse sexuality in general. In contrast, in better-functioning patients in whom loathing and disgust of the female body is a regressive defense against extreme castration anxiety, the working through of that anxiety, of the fear of and revulsion against a powerful and cruel father, and of the inhibition of the capacity for identification with him usually precedes the capacity for tolerating the reemergence of sexual excitement with female genitals.

In perversions as well as in all other cases with severe sexual inhibition, the patient's sexual fantasies as well as activities in masturbation and actual sexual interactions should be carefully explored. Frequently, subtle defensive avoidance of such exploration occurs in the form of the patient's willingness to openly discuss some aspects of his sexual experiences while carefully leaving out other aspects; it sometimes takes many months for the analyst to become aware of the areas that have been avoided.

In other cases, the patient may profusely display chaotic sexual fantasies and activities—in apparently total "freedom" of sexual expression—defensively to avoid central aspects of the transference, particularly primitive types of negative transference dispositions. The patient's chaotic sexual life that characterizes all his other interactions is utilized as a defense against an object relation in depth involving the analyst, and the task is very different: the analysis of the object relation in the transference has to be highlighted and linked to the defensive "smearing" of the analytic situation with primitive sexual material.

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